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The Hope Clinic, Marilynn Conners Frederiksen, M.D., Norman A. Ginsberg, M.D., Cassing Hammond, M.D., Lauren Streicher, M.D., and David Zbaraz, M.D.,

Petitioners,

v.

JAMES RYAN, Attorney General of the State of Illinois, in his official capacity; and RICHARD DEVINE, State Attorney for Cook County, in his official capacity

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

APPENDIX

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In the
United States Court of Appeals
for the Seventh Circuit

No. 98-1726

THE *HOPE* CLINIC, *et al.*,

Plaintiffs-Appellees,

v.

JAMES E. RYAN, Attorney General of Illinois, and
RICHARD K. DEVINE, State's Attorney
of Cook County, Illinois,

Defendants-Appellants.

Appeal for the United States District Court
for the Northern District of Illinois, Eastern Division.
No.97 C 8702—**Charles P. Kocoras**, *Judge*.

Nos. 99-2528 & 99-2533

DENNIS D. CHRISTENSEN, *et al.*,

Plaintiffs-Appellants,

v.

JAMES E. *DOYLE*, Attorney General of Wisconsin,
and DIANE M. NICKS, District Attorney
for Dane County, Wisconsin,

Defendants-Appellees.

Appeals from the United States District Court
for the Western District of Wisconsin.
No. 98-C-0305-S—**John C. Shabaz**, *Chief Judge*.

ARGUED SEPT. 22, 1999—DECIDED OCT. 26, 1999

Before POSNER, *Chief Judge*, and COFFEY, FLAUM, EASTERBROOK, MANION, KANNE, ROVNER, DIANE P. WOOD, and EVANS, *Circuit Judges*.*

EASTERBROOK, *Circuit Judge*. We must decide whether state laws prohibiting partial-birth abortions are unconstitutionally vague or unduly burden women's rights. Acting without an evidentiary hearing, a district court held the Illinois statute unconstitutional and entered a permanent injunction. *Hope Clinic v. Ryan*, 995 F. Supp. 847 (N.D. Ill. 1998). But after a trial, another district court concluded that the Wisconsin statute is valid. *Planned Parenthood of Wisconsin v. Doyle*, 44 F. Supp. 2d 975 (W.D. Wis. 1999). A panel of this court earlier had ordered preliminary relief against Wisconsin's law, see *Planned Parenthood of Wisconsin v. Doyle*, 162 F.3d 463 (7th Cir. 1998), and plaintiffs say that this decision, applying *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), justifies permanent injunctions against both states' rules. To ensure consistency, we heard the appeals en banc. We conclude that both laws *can* be applied in a constitutional manner. *Whether* that will occur depends on state courts, which alone can settle questions about the construction of the statutes. To ensure that physicians are not deterred from performing other medical procedures while issues wend their way through state tribunals, we hold that both sets of plaintiffs are entitled to injunctive relief that will limit the statutes' application to the medical procedure that each state insists is its sole concern.

I

Induction, suction curettage, and dilation and evacuation (D&E) are the principal methods of performing abortions in

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* Circuit Judge Ripple did not participate in the consideration or decision of these cases.

the United States. Prohibiting any one of these would conflict with the right of abortion recognized by cases such as *Casey*, 505 U.S. at 877 (plurality opinion) (adopting "undue burden" as the constitutional standard), and *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 75-79 (1976) (holding that a state may not forbid saline amniocentesis, at the time the principal means of induction). Our cases involve an uncommon procedure known to the medical community as "intact dilation and extraction" or just "dilation and extraction (D&X), and to the public as "partial-birth abortion."

Some medical background is essential to understanding the issues. Induction means inducing preterm labor, which causes the expulsion of the conceptus. Methotrexate or mifepristone (ru-486, now in clinical trials), in combination with misoprostol, can be used for this purpose early in pregnancy; saline amniocentesis and injected prostaglandins serve the same function in the second trimester. Suction curettage (vacuum aspiration), the most common surgical method of abortion early in pregnancy, refers to evacuation of the uterine cavity; the embryo or fetus is separated from the placenta either by scraping or vacuum pressure, then is removed by suction. When these methods are inappropriate, or do not work, physicians employ the D&E procedure. To perform a D&E, the physician dilates the cervix and dismembers the fetus inside the uterus using forceps. Fetal parts are removed with forceps or by suction.

A D&X is a variant of a D&E in which the fetus is removed without dismemberment. The American College of Obstetricians and Gynecologists (ACOG) defines D&X as follows: "1. deliberate dilatation of the cervix, usually over a sequence of days; 2. instrumental conversion of the fetus to a footling breech; 3. breech extraction of the body excepting the head; and 4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus." Martin Haskell, the physician who

developed the D&X procedure, see *Dilation and Extraction for Late Second Trimester Abortion* (1992), reprinted in 139 Cong. Rec. E1092 (Apr. 29, 1993), believes that how the head is diminished in size so that it can pass through the cervix is not important: mechanically crushing the skull serves the same end as evacuating its contents, which causes its collapse. It is this combination of coming so close to delivering a live child with the death of the fetus by reducing the size of the skull that not only distinguishes D&X from D&E medically but also causes the adverse public (and legislative) reaction. Opponents deem the D&X procedure needlessly cruel and bordering on infanticide, and all three states in this circuit have enacted statutory restrictions.

The statute in Illinois has three sections with legal significance:

> 720 ILCS §513/5. Definitions
>
> In this Act: "Partial-birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living human fetus or infant before killing the fetus or infant and completing the delivery. The terms "fetus" and "infant" are used interchangeably to refer to the biological offspring of human parents.
>
> 720 ILCS §513/10. Partial-birth abortions prohibited
>
> Any person who knowingly performs a partial-birth abortion and thereby kills a human fetus or infant is guilty of a Class 4 felony. This Section does not apply to a partial-birth abortion that is necessary to save the life of a mother because her life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering condition caused by or arising from the pregnancy

itself, provided that no other medical procedure would suffice for that purpose.

720 ILCS §513/15. Civil action

The maternal grandparents of the fetus or infant, if the mother has not attained the age of 18 years at the time of the abortion, may in a civil action obtain appropriate relief unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion. The relief shall include money damages for all injuries, psychological and physical, occasioned by the violation of this Act and statutory damages equal to 3 times the cost of the partial-birth abortion.

The Indiana statute defines "partial-birth abortion" in identical terms. Ind. Code §16-18-2-267.5. Like Illinois it forbids partial-birth abortions unless that procedure is necessary to save the mother's life, and no other procedure would suffice. Ind. Code §16-34-2-1(b). The Indiana statute has never been challenged and has been in effect since July 1, 1997.

Wisconsin has taken a slightly different approach. Its statutes provide:

Wis. Stat. §895.038 Partial-birth abortions; liability.

(1) In this section:

(a) "Child" has the meaning given in §940.16 (1)(a).

(b) "Partial-birth abortion" has the meaning given in §940.16 (1)(b).

(2) (a) Except as provided in par. (b), any of the following persons has a claim for appropriate relief against a person who performs a partial-birth abortion:

1. If the person on whom a partial-birth abortion was performed was a minor, the parent of the minor.

2. The father of the child aborted by the partial-birth abortion.

(b) A person specified in par. (a) 1. or 2. does not have a claim under par. (a) if any of the following apply:

1. The person consented to performance of the partial-birth abortion.

2. The pregnancy of the woman on whom the partial-birth abortion was performed was the result of a sexual assault in violation of §940.225, 944.06, 948.02, 948.025, 948.06 or 948.09 that was committed by the person.

(3) The relief available under sub. (2) shall include all of the following:

(a) If the abortion was performed in violation of §940.16, damages arising out of the performance of the partial-birth abortion, including damages for personal injury and emotional and psychological distress.

(b) Exemplary damages equal to 3 times the cost of the partial-birth abortion.

(4) Subsection (2) applies even if the mother of the child aborted by the partial-birth abortion consented to the performance of the partial-birth abortion.

Wis. Stat. §940.16 Partial-birth abortion. (1) In this section:

(a) "Child" means a human being from the time of fertilization until it is completely delivered from a pregnant woman.

(b) "Partial-birth abortion" means an abortion in which a person partially vaginally delivers a living child, causes the death of the partially delivered child with the intent to kill the child, and then completes the delivery of the child.

(2) Except as provided in sub. (3), whoever intentionally performs a partial-birth abortion is guilty of a Class A felony.

(3) Subsection (2) does not apply if the partial-birth abortion is necessary to save the life of a woman whose life is endangered by a physical disorder, physical illness or physical injury, including a life-endangering physical disorder, physical illness or physical injury caused by or arising from the pregnancy itself, and if no other medical procedure would suffice for that purpose.

Wisconsin's definition of partial-birth abortion is substantially the same as Illinois', but the mental-state elements differ, as do the maximum penalties: Illinois makes unjustified partial-birth abortion a Class 4 felony, with a maximum penalty of three years; in Wisconsin the offense is

a Class A felony, for which Wis. Stat. §939.50(3)(a) provides a penalty of life imprisonment.

Because Wisconsin and Illinois use similar language to define partial-birth abortions, we illustrate plaintiffs' concerns with the latter's statute:

> "Partial-birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living human fetus or infant before killing the fetus or infant and completing the delivery. The terms "fetus" and "infant" are used interchangeably to refer to the biological offspring of human parents.

This legal definition is an imperfect match for the medical definition of D&X. It is easy to see why a legislature would be chary of the ACOG's specification: then any small variation (such as a change in the method of reducing the head size, or snipping off a toe to defeat the "otherwise intact" specification) would take the abortion outside the prohibition, even though the reasons why the technique has been deemed objectionable would be unaffected. But, as is common with legislation, the price of avoiding loopholes is generality. Section 513/5 captures the idea, central to the D&X procedure, that an intact fetus moves from uterus to vagina before death occurs. But it also uses the words "delivers" and "delivery," which many physicians understand to refer to any removal of fetal material from the uterus. The law might be read to prohibit the extraction of dismembered parts following a D&E, or to prohibit abortion by induction if by chance the fetus survives until it reaches the birth canal. Moreover, physicians performing a D&E sometimes do not complete the dismemberment inside the uterus, and some fear that this could lead the procedure to be characterized as a partial delivery under the statute.

The possibility that §513/10 might discourage risk-averse physicians from performing the D&E procedure led the district court in Illinois to declare that it is too vague to be enforced, and a similar concern animated our panel's decision to require preliminary relief against Wisconsin's law. Moreover, if these laws needlessly raise the effective costs of induction, suction curettage, or D&E, then they would unduly burden the right of abortion, another concern expressed not only by the district court in the Illinois case but also by the panel in the Wisconsin case. But after a trial on remand, the district court in Wisconsin concluded that physicians who perform abortions recognize that the statutory formula, however vague or broad these words appear to lay eyes, refers to the D&X procedure alone. The court held that, as so limited, the statute does not substantially burden any woman's right to an abortion, because D&X is never the only safe procedure.

Litigation elsewhere has produced results mirroring the divergence between the outcomes in Illinois and Wisconsin. The sixth circuit held that Ohio's ban on partial-birth abortions is unconstitutional, *Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187 (6th Cir. 1997), but the fourth circuit issued a stay preventing interference with Virginia's statute. *Richmond Medical Center for Women v. Gilmore*, 144 F.3d 326 (4th Cir. 1998), motion to vacate stay denied, 1998 U.S. App. LEXIS 18547. Both of those decisions were rendered over dissents. A single panel of the eighth circuit recently held three states' partial-birth-abortion laws unconstitutional, but only after first concluding that all three statutes forbid the D&E procedure. *Carhart v. Stenberg*, 1999 U.S. App. LEXIS 23162 (8th Cir. Sept. 24, 1999) (Nebraska); *Little Rock Family Planning Services, P.A. v. Jegley*, 1999 U.S. App. LEXIS 23165 (8th Cir. Sept. 24, 1999) (Arkansas); *Planned Parenthood of Greater Iowa, Inc. v. Miller*, 1999 U.S. App. LEXIS 23166 (8th Cir. Sept. 24, 1999) (Iowa).

II

Plaintiffs would like us to employ the approach of our panel's opinion in the Wisconsin case and declare both states' laws unconstitutional without ado. But different statutes have different language, which may be important. Litigants also have made distinctive arguments—for example, Illinois relies on *United States v. Salerno*, 481 U.S. 739, 745, (1987), for the proposition that, except in first amendment cases, a law may be held unconstitutional only when "no set of circumstances exists under which the Act would be valid." Moreover, two events since the panel wrote call for fresh analysis. First, that opinion dealt with preliminary relief and observed that "the full trial may cast the facts in a different light". 162 F.3d at 466. That trial has been held in Wisconsin, and its results must be considered. Second, both the panel's decision in the Wisconsin case and the district court's opinion in the Illinois case conclude that the statute as written is vague. A more recent decision of the Supreme Court, *Chicago v. Morales*, 119 S. Ct. 1849 (1999), stresses that state courts are entitled to construe state laws to reduce their ambiguity, and that federal courts should evaluate state laws as they have been construed, not just as they appear in the statute books. See also, e.g., *Parker v. Levy*, 417 U.S. 733 (1974); *Civil Service Commission v. Letter Carriers*, 413 U.S. 548 (1973). This implies that Illinois and Wisconsin are entitled to interpret their own laws—that federal courts should not enjoin all application before enforcement and thus prevent the state courts from having a chance to save their statutes.

Salerno offers a potential ground for giving the states that chance. It would be hard to say that every possible instance of the D&X procedure is protected by the Constitution. Along similar lines are the many cases saying that outside the domain of the first amendment, vagueness challenges must be assessed "as applied." See, e.g., *Maynard v. Cartwright*,

486 U.S. 356, 361 (1988); *Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 494-95 (1982). But we are reluctant to rely too heavily on this approach, because *Morales* shows that three Justices believe that this language is too sweeping, see 119 S. Ct. at 1858-59 & n.22 (Stevens, J., joined by Souter & Ginsburg, JJ.), and the Supreme Court has on occasion resolved constitutional challenges to statutes that do not involve speech without asking whether every conceivable application would be unconstitutional. E.g., *Romer v. Evans*, 517 U.S. 620 (1996); *Kolender v. Lawson*, 461 U.S. 352, 358-59 n.8 (1983); *Nash v. United States*, 229 U.S. 373 (1913). Only one Justice offered any support for *Salerno*'s approach in *Morales*, and he did so in a dissenting opinion. 119 S. Ct. at 1867-72 (Scalia, J., dissenting). Justice Scalia identified many cases that articulate *Salerno*'s requirement, and many others that bypass the inquiry. Courts of appeals are divided on the question whether *Salerno* applies to abortion legislation. Compare *Jane L. v. Bangerter*, 102 F.3d 1112, 1116 (10th Cir. 1996), with *Barnes v. Moore*, 970 F.2d 12, 14 n.2 (5th Cir. 1992). The safest course for a court of appeals, when confronted with inconsistent lines of precedent, is to decide on other grounds if at all possible. Here it is possible, for we think that the Supreme Courts of Illinois and Wisconsin could read their laws in ways that comport with the Constitution.

1. One means of doing this would be to assimilate the statutory definitions to the medical definition of D&X, with allowance for different ways of reducing the head size and other immaterial variations. Both states are concerned about the D&X procedure and did not set out to forbid any other. The Attorneys General of Illinois and Wisconsin, the principal defendants, tell us that their statutes are concerned only with the D&X procedure and will be enforced only against its use. That assurance might be enough by itself, in the absence of any contrary indication from the state judiciary, to resolve immediate vagueness concerns. See

Frisby v. Schultz, 487 U.S. 474, 483 (1988); cf. *Arizonans for Official English v. Arizona*, 520 U.S. 43 (1997). Although local prosecutors (States' Attorneys in Illinois, District Attorneys in Wisconsin) initiate criminal prosecutions, representatives of these prosecutors have been named as parties in each case, and they agree with the Attorneys General. Plaintiffs object that this approach would rewrite rather than interpret the law, but we doubt this. Both medical and popular literature equate "partial-birth abortion" (the statutory term) with the D&X procedure. See Janet E. Gans Epner, Harry S. Jonas & Daniel L. Seckinger, *Late-term Abortion*, 280 J. Am. Medical Ass'n 724 (Aug. 26, 1998); M. LeRoy Sprang & Mark G. Neerhof, *Rationale for Banning Abortions Late in Pregnancy*, 280 J. Am. Medical Ass'n 744 (Aug. 26, 1998). The district court in Wisconsin found that this is the statute's aim. 44 F. Supp. 2d at 984 (relying on the Attorney General's concession). Using a medical definition to supplement a vague lay definition does not strike us as revisionism or an exercise in deconstruction.

But if this approach would nonetheless be an example of brute force used to save a statute--well, courts do it all the time. Florida had a law forbidding "the abominable and detestable crime against nature". Placement in the code showed that this crime had something to do with sex, but what? Did it forbid incest? Necrophilia? Bestiality? A legal historian might give an answer, but to lay readers of the statute, and even to most lawyers, the words are Delphic. The state's highest court filled in the blank by saying that the object was sodomy—and the Supreme Court of the United States rebuffed a charge of unconstitutional vagueness, given the state court's prestidigitation. *Wainwright v. Stone*, 414 U.S. 21 (1973). Only if vagueness remains after judicial interpretation is there a constitutional problem, the Court held. See also, e.g., *United States v. Lanier*, 520 U.S. 259, (1997); *Rose v. Locke*, 423 U.S. 48 (1975); *Lanzetta v. New Jersey*, 306 U.S. 451, 455- 57 (1939); *Kolender*, 461 U.S. at

355-57. Federal courts have performed equally dramatic feats. As written, the Federal Election Campaign Act is hopelessly vague and overbroad. *Buckley v. Valeo*, 424 U.S. 1 (1976), saved the bulk of the statute by adding details. In two recent cases we predicted that state courts would follow suit with comparable state laws. See *Wisconsin Right to Life, Inc. v. Paradise*, 138 F.3d 1183 (7th Cir. 1998); *Brownsburg Area Patrons Affecting Change v. Baldwin*, 137 F.3d 503 (7th Cir. 1998). In the latter case, because we were not completely confident that the state judiciary would follow Buckley's path of freewheeling interpretation, we certified the issue to the Supreme Court of Indiana—which responded that it indeed possesses, and is inclined to use, that power. *Brownsburg Area Patrons Affecting Change v. Baldwin*, 714 N.E.2d 135 (Ind. 1999).

Relying on *Colautti v. Franklin*, 439 U.S. 379 (1979), the sixth circuit concluded in *Women's Medical Professional Corp. v. Voinovich* that any statute concerning abortion is unconstitutionally vague, no matter how precise an interpretation state courts eventually develop, unless it requires proof that the physician knows that a given act has been forbidden. If this were so, then the approach to avoiding vagueness that we have just sketched would be untenable. But it is not so; never has the Supreme Court held that all criminal laws (or even just all criminal laws affecting abortion) depend on scienter. Cases we have mentioned already (and more that we cite later) hold that a statute may be sustained against a charge of vagueness if, as construed, it gives reasonable notice of the forbidden conduct. That the notice does not sink in—that some people close their eyes (or minds) and thus do not learn of the law's contents or appreciate its application to their conduct—does not prevent a state from enforcing its rules. See *United States v. Wilson*, 159 F.3d 280, 288-89 (7th Cir. 1998). This subject received sustained attention in *Karlin v. Foust*, 188 F.3d 446, 460-64 (7th Cir. 1999). For the reasons laid out in *Karlin* we

respectfully disagree with the sixth circuit's understanding of this question. See also Note, 112 Harv. L. Rev. 731 (1999) (criticizing *Women's Medical Professional Corp.*).

2. Although the Constitution does not compel states to ameliorate vagueness problems by using a mental-state requirement to limit prosecutions to situations in which the defendant knows that his acts are forbidden, they are free to do so. This is the path the Supreme Court took in *Screws v. United States*, 325 U.S. 91 (1945), and *United States v. Kozminski*, 487 U.S. 931 (1988), to save 18 U.S.C. §§ 241 and 242. These companion statutes, the poster children for a vagueness campaign, make it a crime to deprive anyone of any constitutional right (or conspire to do so). These statutes are written entirely in terms that have been difficult to pin down, such as "under color of any law" and "rights, privileges, or immunities secured or protected by the Constitution ... of the United States." Section 242 contains the word "willfully", and in *Screws* the Court read this to mean that a person commits the offense only if he *knows* that his acts deprive someone of a constitutional right. A person who actually recognizes his legal obligation can't complain that he lacked notice. Many cases since *Screws* use a knowledge requirement to prevent unfair surprise when the statute is vague or complex. E.g., *Cheek v. United States*, 498 U.S. 192 (1991) (tax laws); *Staples v. United States*, 511 U.S. 600 (1994) (gun-control laws).

Both Illinois and Wisconsin put mental-state elements in their statutes. Attorneys General of both states contend that under their laws a procedure may be deemed a "partial-birth abortion" only if at the outset of the procedure the physician intends to perform all of the steps that mark the D&X. We think that the Supreme Courts of both states could go even farther and read the statutes to require knowledge of the legal rules, and thus to follow the trail blazed in *Screws*.

The critical language in Illinois reads: "Any person who knowingly performs a partial-birth abortion and thereby kills

a human fetus or infant is guilty of a Class 4 felony." 720 ILCS §513/10 (emphasis added). If the Supreme Court of Illinois reads "knowingly" in §513/10 the same way the Supreme Court of the United States read "willfully" in §242, then there is no vagueness problem with §513/10. And we can't see any impediment to giving "knowingly" such a reading. In context, the word sounds distinctly like a requirement that the physician know that the medical procedure being performed is a "partial-birth abortion" and not simply that the physician know that he is performing particular physical acts. The most natural reading is one that requires knowledge of the law's application to the medical procedure being performed. Federal courts have been creative with knowledge requirements as a means of saving statutes against constitutional infirmity. E.g., *United States v. X-Citement Video, Inc.*, 513 U.S. 64 (1994). Section 513/10 readily supports a construction that eliminates all concern about vagueness, which makes it inappropriate for a federal court to enjoin its application. (In *Morales*, the Supreme Court's most recent vagueness opinion, the lead opinion stressed that the statute lacked any mental-state requirement.)

Wisconsin uses the word "intentionally" rather than the word "knowingly." Its statute has two intent elements: a partial-birth abortion is defined as one in which the physician acts with "the intent to kill the child", Wis. Stat. §940.16(1)(b), and the section defining the offense reads: "[W]hoever intentionally performs a partial-birth abortion is guilty of a Class A felony." Wis. Stat. §940.16(2). The reference to "intent" in §940.16(1)(b) must mean "that the actor either has a purpose to do the thing or cause the result specified, or is aware that his or her conduct is practically certain to cause that result." Wis. Stat. §939.23(4) (defining "with intent to"). The reference to "intentionally" in §940.16(2) has at least potentially a broader scope. Although §939.23(3) defines "intentionally" as "a purpose to do the thing or cause the result specified", a "partial-birth abortion"

is neither a thing nor a result; it is a defined legal term. It is therefore a distinct possibility that the Supreme Court of Wisconsin will read this reference as equivalent to "willfully" or "knowingly" notwithstanding the caution in §939.23(5) that criminal intent "does not require proof of knowledge of the ... scope or meaning of the terms used in" a statute. The question here is not whether a physician understands the terms of §940.16(1)(b) in the abstract, but whether the physician intends that the plan of action add up to a "partial-birth abortion." In cases such as *X-Citement Video*, *Cheek*, and *Staples*, the Supreme Court of the United States was exceptionally creative with statutory allusions to mental states; plaintiffs have not established that the Supreme Court of Wisconsin would be unwilling to save its statutes the way the Supreme Court of the United States saved 18 U.S.C. §242.

3. Still a third interpretive approach is open to the state courts. They may elect to apply the statute to its central core of meaning, the D&X, while working out in common law fashion its outer boundaries. See *United States v. Pitt-Des Moines, Inc.*, 168 F.3d 976, 986-90 (7th Cir. 1999). This is how the Supreme Court has chosen to proceed with respect to the Sherman Antitrust Act, 15 U.S.C. §§ 1, 2, a statute much less precise than the partial-birth- abortion laws. Long before the development of a body of antitrust rules, or even of a clear distinction between the domains of the per se rule and the rule of reason, the Court rebuffed a vagueness challenge, remarking that "law is full of instances where a man's fate depends on his estimating rightly, that is, as the jury subsequently estimates it, some matter of degree." *Nash*, 229 U.S. at 377 (Holmes, J.). The Court took the same approach in *Parker v. Levy* for Article 133 of the Uniform Code of Military Justice, which makes it a crime for a commissioned officer to engage in "conduct unbecoming an officer and a gentleman." That statute, compared to which §513/5 and §940.16(1)(b) are paragons of specificity, was sustained

against a vagueness challenge because the military courts had added details over many years, and the Supreme Court anticipated that they would continue to do so as new situations arose. *Letter Carriers* applies the same approach to vague provisions of the Hatch Act. *Parker* cannot be passed off as a sport of military law; it is just one illustration of the proposition that vagueness may be overcome incrementally, as well as by an all-at-once construction. Consider *United States v. Powell*, 423 U.S. 87 (1975), a civilian case dealing with 18 U.S.C. §1715, which makes it a crime to mail a firearm capable of being concealed on the person. A Derringer unquestionably qualifies, and although larger guns pose tough questions, the combination of a core meaning plus size as a metric for adjudication enabled the Court to hold that borderline cases could be decided later, as they arose.

Notice the difference between this approach and *Salerno*. In cases such as *Nash*, *Parker*, and *Powell*, the Court did not ask simply whether there was one constitutional application. It asked whether there was a core of meaning that people could grasp. In *Nash* the common law of restraint of trade supplied that core; in *Parker* the accumulated body of military precedents did so; in *Powell* the core comprised handguns. Occasionally the Court fortifies this approach by combining it with a scienter requirement, as *United States v. United States Gypsum Co.*, 438 U.S. 422 (1978), did for the Sherman Act. Illinois and Wisconsin can follow the same path. For their statutes, the medical definition of the D&X procedure supplies the core of understandable application. Indeed, the district court in Wisconsin found as a matter of fact that physicians who are likely to perform an abortion already understand that this is the point of partial-birth-abortion statutes. 44 F. Supp. 2d at 978. That finding cannot be set aside as clearly erroneous.

Plaintiffs respond to this core-plus-common-law approach by contending that a statute is unconstitutionally vague until the interstices have been filled in. But then all of

the cases we have cited were wrongly decided, for the interstices of antitrust law were not filled in by 1913, nor were all of the gun-mailing issues worked out before 1975: *Powell* involved a sawed-off shotgun, not a pistol. To say that the law cannot be applied to *anyone*, even a person who commits a violation within the core of the statute, until all issues about its reach have been resolved would prevent those issues from coming before the court to *be* resolved. How, precisely, are the interpretive wrinkles to be smoothed if the law can't be invoked? By advisory opinions? Anyway, there is always a periphery, no matter how many situations judges have evaluated. Resolving each new question moves the area of uncertainty but can't abolish it. "Whenever the law draws a line there will be cases very near each other on opposite sides. The precise course of the line may be uncertain, but no one can come near it without knowing that he does so, if he thinks, and if he does so it is familiar to the criminal law to make him take the risk." *United States v. Wurzbach*, 280 U.S. 396, 399 (1930) (Holmes, J.).

Protection for events outside the core is provided by the principle that surprising and unanticipated applications of a criminal statute violate the due process clause. See, e.g., *Bouie v. Columbia*, 378 U.S. 347, 351 (1964); *Marks v. United States*, 430 U.S. 188, 196 (1977); *Lanier*, 520 U.S. at 266. Given the assurances made in this litigation by the Attorneys General of Illinois and Wisconsin, application of these states' partial-birth-abortion statutes to a normal D&E or induction (including one that began as a D&E but turned out to have elements of a D&X because of inadvertence or developments during surgery) would be surprising and constitutionally impermissible. Plaintiffs therefore can practice medicine without undue concern on the legal front. The Constitution provides the assurance they crave—but without the need to prevent application of the state law to the D&X procedure itself. States have a powerful interest in working out the details of their criminal laws in their own

courts. See *Younger v. Harris*, 401 U.S. 37 (1971); *Nelson v. Murphy*, 44 F.3d 497 (7th Cir. 1995). On remand the district judges should enter precautionary injunctions, limited to implementing the conclusion of this paragraph that the state laws may not be applied to a normal D&E or induction until after the state has provided additional specificity, by statutory amendment, regulations, or judicial interpretation (which could arise either from civil litigation, see Part IV below, or from criminal prosecutions in which the parties disagree about whether the medical procedure properly may be labeled a D&X). With that assurance in hand, plaintiffs would not face any *substantial* threat of prosecution.

A skeptic might respond: what's the basis for an injunction without a finding of actual constitutional violation? The basis is the risk that plaintiffs face. See *Ex parte Young*, 209 U.S. 123 (1908). Whenever suit is brought against a statute that has yet to be enforced, there is a chance that what the federal court does will be unnecessary or even advisory--for in the absence of relief the statute might never be enforced in a way that plaintiffs fear, or that would violate their rights. Everything depends on probabilities. Plaintiffs believe that the probability of improper prosecution is so high that the statutes must be enjoined root and branch. We think that the probability of improper prosecution is low, but non-zero; and a prosecution for performing a D&E not only raises vagueness concerns but also could unduly burden women's rights (see Part III below). That risk can be reduced to a constitutionally acceptable level with a simple injunction based on *Bouie*.

Persons who believe that the risk of improper prosecution is so high that all prosecution under the statute should be enjoined are poorly situated to contend that the risk also is so low that the plaintiffs lack standing under *Los Angeles v. Lyons*, 461 U.S. 95 (1983). When this case began the plaintiffs faced a real risk and therefore had standing; and no one thinks that defendants' representations about their

projected course of enforcement have made the controversy moot. If as plaintiffs believe the Constitution requires an injunction against everything Illinois and Wisconsin have enacted, *despite* these assurances, then the Constitution can't simultaneously forbid an injunction against potential misuses of state power in the enforcement of these laws. Article III does not limit a federal court's choice to enjoining nothing, or enjoining everything. The path we choose allows the states to interpret their laws and supply more concrete rules, see *Bellotti v. Baird*, 428 U.S. 132, 146-47 (1976); the path the plaintiffs (and our dissenting colleagues) prefer would foreclose now and forever all interpretation by the state judiciary. By filing suit against a novel and ambiguous law in federal court, litigants can't preclude interpretation by the state judiciary. Our precautionary approach preserves the state judiciary's role while protecting plaintiffs' (and their patients') legitimate interests in the interim.

4. In the Wisconsin case our panel expressed concern that even if the probability of unanticipated application is low, the penalty is so high (life imprisonment) that physicians would avoid performing the D&E procedure. 162 F.3d at 469. This cannot be said of Illinois, where the maximum penalty is three years' imprisonment. Although the threat of life in prison has a greater potential to induce caution than does the threat of three years in prison, the precautionary injunction discussed above should reduce the risk of improper or unanticipated application to a trivial level. The right constitutional objection to a Draconian penalty is not vagueness (a statute's scope is equally clear or uncertain whether the penalty is a $10 fine or 20 years in prison) but a contention that severe criminal punishment for a medical misunderstanding would inflict cruel and unusual punishment. Plaintiffs themselves do not make such an argument, however; they object to the substance of the state laws, not to the punishment available on conviction. The penalty is an afterthought, scarcely mentioned in their briefs.

If Wisconsin should some day impose a lengthy prison term for a violation of §940.16(2), then it will be time to consider arguments based on the eighth amendment.

5. For the last two years, a natural experiment has been conducted in the United States. Thirty states enacted laws forbidding most partial-birth abortions. Judges prohibited the application of these laws in two-thirds of these states; in the other third the statutes have been in force. One way to perform a reality check on the district court's conclusion in the Wisconsin case that physicians know that these statutes cover only the D&X is to see what has happened in the states where the laws have been permitted to take effect. Vagueness could affect physicians in either or both of two ways. First, they might send women seeking second-trimester abortions to other states that do not regulate partial-birth abortions. The result would be a decrease in second-trimester abortions as a percentage of all abortions in the state. Second, physicians might select a different procedure—principally substituting induction for a D&E—even though the replacement was medically inferior. This would produce a change in the ratio of inductions to D&E procedures in the affected state.

Indiana supplies a nice test, because its law took effect on July 1, 1997, so it is easy to compare the first six months of 1997 to the second six. Moreover, Indiana is surrounded by states that lack an effective prohibition on partial-birth abortions (because of the Illinois injunction and the sixth circuit's ruling in *Women's Medical Professional Corp.*), so it was relatively easy for physicians to send their patients elsewhere. Although the maximum penalty in Indiana is not steep (an unjustified partial-birth abortion there is a Class C felony, Ind. Code §16-34-2-7(a), for which the punishment is four years' imprisonment, Ind. Code §35-50-2-6(a)), no state or federal court has construed the statutory term, so whatever uncertainty the raw text of the statute engenders is unabated.

During 1997 a total of 13,208 abortions were performed in Indiana. (These data come from tables prepared by

Indiana's State Epidemiologist.) During the first six months, 74 late-second-trimester abortions were performed: 72 by D&E and 2 by intra-uterine prostaglandin injection. During the second six months (that is, after the partial-birth-abortion law took effect), 87 late-second-trimester abortions were performed, all by D&E. Thus physicians did *not* substitute induction for D&E in order to reduce risk to themselves. Nor did they avoid the D&E procedure by sending women to other states. Abortion by D&E during the first six months represented 1.03% of all abortions performed in Indiana (72 of 6,950). Abortion by D&E during the second six months represented 1.39% of all abortions in the state (87 of 6,258). These data are incompatible with plaintiffs' *a priori* belief that the partial-birth-abortion statutes will discourage the performance of the D&E procedure or cause the physician to substitute an inferior procedure. Perhaps things have turned out differently in other states, or perhaps physicians behaved differently in 1998 or 1999. We do not mean to preclude plaintiffs from submitting the data in Indiana and other states to rigorous analysis. A few procedures were classified in the tables as "unknown," which may mask some effects—though the number of "unknown" procedures did not change much from the first to the second half of 1997. Our point is only that a simple inquiry reinforces the findings of fact made in the Wisconsin case and implies that partial-birth-abortion statutes need not have the baleful effects that plaintiffs foresee.

III

Plaintiffs in both cases contend that, even if the statutes are precise enough to be enforced, they create an undue (and therefore unconstitutional) burden on abortion. The eighth circuit reached this conclusion in *Carhart* and its two companion cases, but only after first holding that the state laws effectively prohibit the D&E procedure. If we thought

that the Illinois or Wisconsin laws forbade D&E, then *Planned Parenthood of Central Missouri v. Danforth* would require us to agree with the eighth circuit. For reasons we have already given, however, we believe that state courts are entitled to accept the view of both states' Attorneys General that their laws do not forbid, or even affect, the D&E procedure. The question we must address, then, is whether a statute limited to D&X unduly burdens abortion.

One reason why this might be so is that neither state's law contains an exception for situations in which the D&X procedure is necessary to protect the woman's health. A second argument is that any prohibition of any medical procedure unduly burdens a woman's right to abortion. The first line of argument finds some support in *Casey*, which held that any regulation of abortion must make an exception for procedures that protect "the woman's life *or health*", 505 U.S. at 846 (emphasis added), as well as our panel's decision in the Wisconsin case, 162 F.3d at 467-68, 470-71. But we do not think that the plurality in *Casey* meant this as a universal rule, one applicable even when the procedure in question lacks demonstrable health benefits. The point that the plurality made was that a statute that lacks a "health exception" may unduly burden the woman's right to obtain an abortion before the fetus has reached viability; when state law offers many safe options to that end, the regulation of an additional option does not produce an undue burden.

Section 513/10 of the Illinois statute contains an exception for "a partial-birth abortion that is necessary to save the life of a mother because her life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering condition caused by or arising from the pregnancy itself, provided that no other medical procedure would suffice for that purpose." It does not contain a comparable exception for a partial-birth abortion that promotes the woman's health. Wisconsin's law has a similar structure. Both sets of plaintiffs contend that the lack of an

exception for a woman's health dooms the statute. Coming from the Illinois plaintiffs, this is a weak argument indeed, for *none* of the plaintiff physicians or clinics in Illinois uses the D&X, and none asserts any desire to start. Whether the D&X procedure sometimes would protect a woman's health is therefore immaterial to *these* physicians and the women in their care. But several of the plaintiff physicians in the Wisconsin case do employ the D&X procedure on occasion, so we must consider the merits of the argument.

After a trial, the district court in the Wisconsin case concluded that the D&X procedure is *never* necessary from the perspective of the patient's health. 44 F. Supp. 2d at 979-82. This conclusion cannot be called clearly erroneous; as things transpired, it was not a seriously contested issue. None of the plaintiff physicians in that case testified to the contrary. The district court summed up:

> None of the physicians would state unequivocally that the D&X procedure is safer than the D&E procedure. Broekhuizen conceded that further study of the procedures is required. Smith admitted that he had never encountered a situation where D&X would have been the best procedure to use. Haskell, who invented the procedure, admitted that the D&X procedure is never medically necessary to save the life or preserve the health of a woman. Giles agreed.

Id. at 980. The judge added that, although the D&X procedure has been used for more than a decade, no published study compares the risks of D&X to those of D&E. *Id.* at 979. Some authors believe that the D&X procedure is more hazardous. See Sprang & Neerhof, *supra*, 280 J. Am. Medical Ass'n at 746 ("Intact D&X (partial-birth abortion) should not be performed because it is needlessly risky, inhumane, and ethically unacceptable."); Nancy G. Romer,

The Medical Facts of Partial-birth Abortions, 3 Nexus 57 (1998).

Plaintiffs have not identified any data that undercut the district court's finding of fact. Their principal medical reference is the ACOG's 1997 statement and technical bulletin on the D&X procedure, which concluded that, although D&X is never the only medically appropriate option, choice still should be reserved to the physician. Although the statement asserts that D&X sometimes may be the best option, the ACOG did not identify any concrete circumstance under which this would be so or provide support for the assertion. Several of the plaintiff physicians testified to like effect, again without specifics or data. No published medical study fills the gap. Cf. *Kumho Tire Co. v. Carmichael*, 119 S. Ct. 1167, 1177-79 (1999). Unelaborated avowals do not demonstrate that a finding of fact reached after a trial is clearly erroneous. When there is a conflict in the testimony—and that is the description most favorable to the plaintiffs—the finder of fact is entitled to choose. See *Anderson v. Bessemer City*, 470 U.S. 564 (1985). We proceed on the assumption, which appears to be shared by the American Medical Association, that the D&X is not the best or safest option in any articulable category of situations. The AMA's Policy H- 5.982 concludes, among other things, that "there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion." The district court in Illinois did not make contrary findings, or indeed *any* finding; acting without a trial or even an evidentiary hearing, it could not properly have rendered "findings" about disputed issues. District courts in other circuits have disagreed with the conclusions the district judge reached in the Wisconsin case, but this does more to show that the issue is debatable among reasonable persons than to show that a particular view is in error.

The question in the end is not what one or another judge found on a given record; it is whether the state legislatures

exceeded their constitutional powers. Factual premises underlying legislation normally are not subject to review by trial courts. *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 315 (1993); *Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 463-65 (1981); *Vance v. Bradley*, 440 U.S. 93, 111 (1979); *National Paint & Coatings Ass'n v. Chicago*, 45 F.3d 1124, 1127 (7th Cir. 1995). The district court's findings, the statements of medical groups, and the inferences to be drawn from what has happened in states that have implemented partial-birth-abortion statutes, are informative rather than conclusive on the question whether the underpinnings of the legislation are tenable. See Henry P. Monaghan, *Constitutional Fact Review*, 85 Colum. L. Rev. 229 (1985). Although "undue burden" analysis does not map neatly to the standard classifications ("rational basis," "strict scrutiny," and the like), making it hard to know the extent to which courts must respect legislative decisions about contestable factual matters, it is significant that none of the Supreme Court's decisions in abortion cases suggests that the same law would be constitutional in one state, and unconstitutional in another, depending on a district judge's resolution of factual disputes. Thus we treat the findings in the Wisconsin case, like the view of the AMA, not as replacements for legislative conclusions, but as establishing that there is real, and not just hypothetical, support for a belief that the partial-birth-abortion laws do not pose hazards to maternal health. (This is the approach to evaluation of facts when the constitutional standard prescribes an intermediate level of analysis. See *Craig v. Boren*, 429 U.S. 190, 199-204 (1976).)

Only if every regulation related to abortions must contain a case-by-case "health exception" is there a problem with these laws. Yet *Casey* did not say that health effects must be evaluated case by case, rather than procedure by procedure. Abortions are not havens for junk science—so that, for example, the state must let any chiropractor perform an

abortion, if the chiropractor believes that manipulation of the spine is safest for the woman. Cases such as *Mazurek v. Armstrong*, 520 U.S. 968 (1997), which held that states may limit performance of abortions to physicians, permit laws that regulate by class of procedures (or of medical providers). Cf. *United States v. Rutherford*, 442 U.S. 544 (1979) (FDA may ban a generally ineffective drug, even though for a few people it may be the only cure). Doubtless some nurses are better than some physicians at performing abortions, so patients' health would be improved by allowing these nurses to perform abortions; yet the Court held that states may provide otherwise. Similarly, Illinois and Wisconsin concluded that the D&X procedure is not essential to protect the health of any woman, given the availability of other procedures. Compilation of additional information by the medical profession could call this conclusion into question. As things stand, however, interference with the operation of the state laws cannot be justified on the ground that the D&X procedure is necessary to protect women's health.

A requirement of a case-by-case "health exception" to every statute concerning abortion would amount to a rule that no state may regulate any abortion procedure. For a physician will use a particular procedure only if in the physician's judgment the procedure is superior in some way—faster, safer, more likely to work (and thus indirectly safer because an abortion can be achieved with one procedure rather than two, with cumulative risks), or perhaps less expensive (and thus again indirectly safer, because the lower cost brings it within the reach of additional patients). Can plaintiffs, who object to the vagueness of the states' laws, really welcome a ruling under which every abortion creates the possibility of a prosecution in which the state invites a jury to disagree with the physician's assessment of the procedure's safety? A health exception, where jurors rather than physicians assessed health, would be an order of magnitude worse than the ambiguity plaintiffs perceive in the partial-birth-abortion

laws. Perhaps plaintiffs believe that a "health exception" should make the physician's assessment of health consequences incontestable. That would avoid vagueness at the price of vitiating the laws. Some physicians are bound to think that a given procedure is safer or otherwise superior, even if the medical profession as a whole disagrees. A constitutionally based health exception for *every* procedure, coupled with a prohibition against review of physicians' beliefs about which procedures are safest, would amount to a rule that anything goes. And plaintiffs make this argument explicitly: they contend that any regulation of any medical procedure that pertains to abortion is an "undue burden" on women's rights.

To the observation that D&X is not an important procedure—indeed, that it is such a marginal procedure that few physicians anywhere in the nation (and none in Illinois) express any interest in performing it—plaintiffs rejoin that the question is not whether a law creates an undue burden for women as a group, but only whether it does so for those women it affects. The affected set here is women for whom a physician will think that D&X is the procedure most likely to succeed, or to entail the least cost. For *these* women, plaintiffs contend, the burden is substantial and therefore "undue." Moreover, the argument continues, if the states are right—if D&X really is a procedure that the medical profession abjures—then the law must be political grandstanding. A restriction imposed for no better reason than to make a point has no benefits and therefore must be "undue," the argument concludes. On plaintiffs' approach, if the statutes actually accomplish something, then the burden is "undue" because the laws have effects; and if the laws accomplish nothing, then the burden is "undue" because any cost is excessive when the benefit is zero. Plaintiffs have the states both coming and going.

But this cannot be a sound understanding of *Casey*, or *Mazurek* would have come out the other way. By plaintiffs'

lights, Montana's statute restricting the performance of abortions to licensed physicians would have had an "undue burden" on those women it affected—that is, the set of women for whom the extra cost of a physician's fees made obtaining an abortion impractical or burdensome. Yet the Court held that a physician-only rule is not an "undue burden," as the plurality in *Casey* used that phrase. What plaintiffs in our case really argue is not that limiting the D&X procedure to situations (if there are any) in which it is necessary to save the woman's life is an undue burden, when compared with other burdens (such as waiting periods, information requirements, parental approval or consultation requirements, and physician-only rules) that the Court has sustained; it is, rather, that *all* "burdens" are "undue" because women should have unfettered choice among medical procedures. But then the phrase "undue burden" is simply redundant; the word "undue" does no work.

It is always difficult for a court of appeals to predict how Justices of the Supreme Court will apply a phrase with as much plasticity as "undue burden." But our best estimate is that "undue" rather than "burden" is the key word, and that "undue" means not only "substantial" (a small cost or inconvenience is not "undue") but also that the burden must be undue in relation to the woman's interests, rather than undue in relation to the court's assessment of society's interests. Plaintiffs' (implicit) argument that every regulation of a medical procedure is "undue" fails because many regulations create small burdens. The physician-only rule was one; a prohibition of D&X is another. Even for the class of women who seek late-second-trimester abortions, there is always one or more other safe methods of abortion in addition to D&X. Let us return to the natural experiment now under way. Plaintiffs do not contend that in any of the states where a partial-birth-abortion law is in effect, even one woman has been injured or denied an abortion because of the law.

As for the second branch of plaintiffs' argument--that because the partial- birth-abortion laws do not diminish the number of abortions, they must be condemned as moralizing rather than utilitarian laws—this calls on judges to recapitulate *Lochner's* methodology. This line of argument amounts to the contention that *Casey* so restricts the states' power that states are limited to symbolic gestures; and then the states' very attempt to comply with *Casey* by refraining from substantially impeding women's access to abortion dooms their laws. We do not read *Casey* as condemning states to this self-defeating legislative menu. So long as the law does not harm women's legitimate interests, the fact that the law's effects are small and justified by moral rather than utilitarian considerations does not spell unconstitutionality.

IV

One final issue requires attention. The district court in Illinois read 720 ILCS §513/15 to establish a parental-consent requirement, which the court enjoined because it lacks a judicial-bypass procedure. 995 F. Supp. at 861, relying on a portion of *Casey*, 505 U.S. at 899-900, that reaffirmed *Hodgson v. Minnesota*, 497 U.S. 417 (1990). But what §513/15 actually provides is different. It reads:

> The maternal grandparents of the fetus or infant, if the mother has not attained the age of 18 years at the time of the abortion, may in a civil action obtain appropriate relief unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion. The relief shall include money damages for all injuries, psychological and physical, occasioned by the violation of this Act and statutory damages equal to 3 times the cost of the partial-birth abortion.

Nothing here requires parental consent to a partial-birth abortion. Section 513/10 *forbids* most partial-birth abortions; no one can authorize that procedure in Illinois unless it is necessary to protect the woman's life, and then no parent's consent is necessary.

Section 513/15 provides civil damages for conduct that violates §513/10, and it assigns the right to pursue these damages to parents if the person who undergoes the procedure is a minor. A parent who gave consent to the procedure naturally can't recover damages, even though a criminal prosecution remains possible under §513/10 if the mother's life was not in jeopardy. The possibility that a parent may consent to an unlawful procedure (and thus insulate the physician from civil damages), or consent to a life-saving procedure for which no consent was necessary in the first place, hardly implies that a judge also must be empowered to authorize a violation of §513/10.

Wisconsin's civil-liability provision, Wis. Stat. §895.038 (2), is entirely derivative from its criminal-liability provision, and the district court held it valid because the criminal provision is valid. Plaintiffs in the Wisconsin case do not take issue with this approach: they argue only that §895.038(2) is unconstitutional because §940.16 is unconstitutional. We therefore do not discuss §895.038(2) further.

Actually, we have said too much already about the civil-liability provisions. They are enforced in private litigation; the states' Attorneys General and local prosecutors have nothing to do with civil suits. Relief against the public officials therefore would be pointless even if the civil-liability provisions were problematic. See *Summit Medical Associates, P.C. v. Pryor*, 180 F.3d 1326 (11th Cir. 1999). There is no controversy between the parties to this case that can be resolved by a declaration concerning the civil-liability rules. But see *Okpalobi v. Foster*, 1999 U.S. App. LEXIS 22785 (5th Cir. Sept. 17, 1999) (purporting to enjoin a

private-civil-damages provision in a suit to which only state officers were defendants, without mentioning the eleventh circuit's conclusion in *Summit Medical*).

The judgments in both cases are vacated. The cases are remanded with instructions to enter the precautionary injunctions discussed in Part II.3 of this opinion, to dismiss the challenges to the civil-liability provisions for want of a case or controversy, and otherwise to enter judgment for the defendants.

VACATED AND REMANDED

POSNER, *Chief Judge*, with whom ROVNER, DIANE P. WOOD, and EVANS, *Circuit Judges*, join, dissenting. Compromise holds seductive allure for a court faced with a hot issue, and there is none hotter than the issue of abortion rights. The Illinois and Wisconsin statutes criminalizing "partial birth" abortion are challenged here both as being unconstitutionally vague and as unconstitutionally burdening the right of abortion. (These are independent grounds; if either is valid, the statutes are invalid.) The court rejects both challenges yet orders the district courts to enjoin enforcement of the statutes against any method of abortion other than the one the medical community refers to as "intact D & E" (that is, intact dilation and evacuation) or, more commonly, "D & X" (dilation and extraction). This is the form of "partial birth" abortion that gave rise to these statutes, although they are not limited to it.

The court's decision is not a real compromise. It leaves intact the core of the statutory prohibitions, which unlawfully burden the right of abortion by outlawing the D&X procedure. The court does toss a bone to the plaintiffs, but at the cost of expanding federal judicial power over the states by a method that the Supreme Court has never countenanced and that violates Article III of the Constitution. It is a bone, incidentally, that the plaintiffs didn't ask for; neither side, in either case, requested this novel form of relief or commented

on it in their briefs. We are taking a leap into the unknown without any input from the parties.

The "precautionary" injunctions that the court is directing the district courts to enter will forbid the enforcement of the statutes outside their core prohibition, thus placing the federal contempt power behind this court's interpretation of state statutes. The court does this while accepting the enforcers' assurances that they will not enforce the statutes outside the core, and concludes, therefore, "that the probability of improper prosecution is low." The states are nevertheless to be enjoined because the probability, though low, is greater than zero. The probability of improper prosecution under *every* criminal statute ever written is greater than zero; and so the court's decision, should it be followed outside the abortion context—and nothing in the decision suggests a principled limitation to that context—implies a radical expansion of the power of the federal courts to superintend the enforcement of state statutes. State officials will be subject to federal contempt sanctions for failing to abide by a federal court's interpretation of the statutes that these officials, not federal judges, are charged with administering.

The court adds that while the probability of improper enforcement *now* is low, given the assurances that the state law enforcement authorities have made in their briefs in this court and at oral argument, the probability was high enough when these cases were brought to confront the plaintiffs with "a real risk" of being prosecuted for performing constitutionally privileged abortions. But if that is so, it means the statutes are unconstitutionally vague. If the law enforcers' present assurances are not enough to moot the case, how can they be enough to moot the central issue to which those assurances are addressed, the issue the court ducks of whether the statutes are in fact unconstitutionally vague? And if the present probability of improper enforcement is slight, as the court believes, what *equity* do the plaintiffs have to obtain an injunction?

The court is directing that state statutes be enjoined that it has not found either violate federal law or create a significant danger of such violation. This is unprecedented, and (on the court's view of the facts) violates Article III. If the court is right—I do not think it is, but it is the premise of the decision—that there is only a "non-zero" probability that either state statute will be enforced against any abortion procedure other than the D&X, the threatened injury is too slight to activate the curative powers of federal courts. A nonzero probability could be a probability of one in a thousand, or one in a million. A probabilistic injury can support standing, e.g., *Clinton v. City of New York*, 118 S. Ct. 2091, 2100-01 (1998); *Walters v. Edgar*, 163 F.3d 430, 434 (7th Cir. 1998); *North Shore Gas Co. v. EPA*, 930 F.2d 1239, 1242 (7th Cir. 1991), but the probability must be nontrivial, not merely nonzero. E.g., *Murphy v. Hunt*, 455 U.S. 478, 482-83 (1982) (per curiam); *City of Los Angeles v. Lyons*, 461 U.S. 95, 105-07 and n. 8 (1983); *Walters v. Edgar*, *supra*, 163 F.3d at 434-35. Otherwise the federal courts will be flooded with cases, since few statutes are altogether free of vagueness; statutes that are too precise allow loopholes.

Lyons, the choke-hold case, makes the basic point. The probability that the plaintiff would again be arrested and subjected to a choke hold was held to be too slight to support standing. But it was no less than the implicit probability that this court today assigns to the threat of prosecution for performing abortions that the state law enforcement authorities concede are constitutionally privileged.

Although the injunctions that the court is ordering ostensibly are temporary, to remain in force only until the state courts have a chance to clarify the statutes, those courts are unlikely ever to get that chance, since the enforcement of the statutes beyond their core prohibition, which in the court's view needs no clarification, will be enjoined. Private civil suits are unaffected, but the provisions for civil enforcement of these statutes are limited and cases are

unlikely. The Illinois statute authorizes civil suits only by the parents of a minor who has a "partial birth" abortion, and the Wisconsin statute by either the minor's parent or the fetus's father. Should a prosecutor indict a physician for performing a D&X, and the physician contend that it was really a D&E, the dispute will be resolved by the district court's interpreting its injunction in contempt proceedings. As a practical matter, the courts of Illinois and Wisconsin will never have an opportunity to explore the outer bounds of these statutes.

The court cites no case that authorizes such injunctions. It relies on cases such as *City of Chicago v. Morales*, 119 S. Ct. 1849, 1861, (1999), and *Village of Hoffman Estates v. The Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 494 n. 5 (1982), which hold that if a state statute has been interpreted by the state's highest court, that *until* the statute is construed by the state courts, a claim that is unconstitutionally vague is premature. No case denies the authority of the federal courts to interpret state statutes, which is something we do all the time. No case holds that until a state statute is construed by the state courts its operation may be enjoined without a determination, that the statute is unconstitutional. All the cases on which the majority relies involve federal courts either narrowing federal statutes that are fairly susceptible of being narrowed or accepting as authoritative a narrowing interpretation of a state statute by a state court. In no case cited by the majority did a federal court impose its own narrowing interpretation on a state statute by injunction, let alone a state statute the language of which defies a saving interpretation.

Although grounded in a concern with preserving the prerogative of state courts to interpret state statutes, today's decision curtails that prerogative by forbidding the states to enforce state statutes that the court has *not* found to be invalid. The decision is thus internally inconsistent (the court both rejects the charge that the statutes are unconstitutionally vague and, by enjoining their application outside their small

clear core until they are clarified by the state courts, holds that they are too vague to provide fair warning--which means they are unconstitutionally vague, e.g., *Bouie v. City of Columbia*, 378 U.S. 347, 351 (1964)), as well as being an evasion of judicial duty, a violation of Article III, and an affront to federalism. The content of the injunctions that the court orders entered, moreover, is not specified; disputes over it will undoubtedly give rise to further litigation. And there will be a nice question of whether the plaintiffs can obtain attorneys' fees on the ground that they have won *something*, with the defendants arguing that it is *they* who have won the case because the court has both held the challenged statutes to be valid and accepted the defendants' assurances that the statutes will not be enforced beyond their valid scope.

On the merits, the most important issue raised by the appeals is that of undue burden. (I'll come back later to the substantive issue of vagueness, as distinct from the problems raised by the court's effort to evade the issue by means of the "precautionary" injunctions.) To understand this issue requires understanding the peculiar and questionable character of these statutes. They do not protect the lives of fetuses either directly or by seeking to persuade a woman to reconsider her decision to seek an abortion. For the statutes do not forbid the destruction of any class of fetuses, but merely criminalize a *method* of abortion—they thus have *less* to recommend them than the antiabortion statutes invalidated in *Roe v. Wade*, 410 U.S. 113 (1973). If any fetal lives are saved by these statutes, it will only be by scaring physicians away from performing *any* late-term abortions, an effect particularly likely in Wisconsin, whose statute imposes a punishment of life imprisonment for its violation. In tacit acknowledgment of that statute's especially questionable character, the majority opinion invites an Eighth Amendment challenge should a lengthy prison sentence ever be imposed on a violator of the statute.

The statutes do not seek to protect the lives or health of pregnant women, or of anybody else, as by confining the performance of abortions to licensed physicians, as in *Mazurek v. Armstrong*, 520 U.S. 968 (1997) (per curiam), or to facilities equipped to deal with emergencies that may arise in the course of an abortion, particularly a late- term one. A legislature can ban quacks from practicing medicine without making an exception for those quacks (and no doubt there are some) who are abler than the worst physicians. Any general health regulation is likely to hurt a few people. But as banning "partial birth" abortions is not intended to improve the health of women (or anyone, for that matter), it cannot be defended as a health regulation.

The statutes make no exception for cases in which pregnancy results from rape or incest, or in which the fetus is profoundly deformed, nonviable, or unlikely to live more than a few hours after birth, or indeed, as I shall show, in which the woman's life would be endangered if she carried the fetus to term. The absence of any such exceptions is particularly surprising because late-term abortions are much less likely than the much more common first-trimester abortions to be motivated by considerations merely of convenience rather than of urgency. A woman who finds herself five months pregnant is unlikely to decide to have an abortion unless advised by her physician either that the fetus is profoundly deformed or that her own health requires that the pregnancy be terminated. Indeed, if the fetus has become viable, she *cannot* lawfully obtain an abortion unless her life or health is in danger. Wis. Stat. § 940.15(3); 720 ILCS 510/5(1). These are constitutionally permissible protections of fetal life. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 879 (1992). It is incomprehensible to me why these states, if acting in good faith, were unwilling to write the same health exception into statutes that criminalize the abortion of nonviable as well as viable fetuses. The "partial birth" statutes do not distinguish

between fetuses that are viable, in the sense of being sufficiently developed to be able to survive outside the mother's body, and those that are not. Some fetuses don't become viable until 27 weeks or even later, but the "partial birth" abortion, even defined so narrowly as to cover only the D&X procedure, is performed from 20 weeks on. A physician might be convicted of a felony violation of these statutes even though the Supreme Court has held that a state may not prevent the abortion of a nonviable fetus. *Id.* at 846, 877.

The statutes do not outlaw a particularly cruel or painful or horrifying mode of abortion. This can be shown with the aid of a simple example. Suppose that the fetus is hydrocephalic, so that its head is too large to pass through the cervix. If the physician performing the abortion crushes the fetus's skull in the uterus, killing the fetus while the fetus is still entirely within the uterus, he is not guilty of violating either of the statutes before us. But if before crushing the fetus's skull the physician turns the fetus around so that its feet are protruding into the vagina, he has committed a felony. In both cases, the fetus is killed by the crushing of its head in the uterus. (The crushing is necessary to enable the fetus to be removed through the birth canal without making the woman go into labor.) From the standpoint of the fetus, and, I should think, of any rational person, it makes no difference whether, when the skull is crushed, the fetus is entirely within the uterus or its feet are outside the uterus. Yet the position of the feet is the *only* difference between committing a felony and performing an act that the states concede is constitutionally privileged.

The tortured efforts of the states' lawyers to provide guidance to physicians engaged in performing abortions—physicians who already are frequent subjects of picketing and other harassment and occasionally of physical assaults, see, e.g., *United States v. Soderna*, 82 F.3d 1370 (7th Cir. 1996), and who are now to be threatened with criminal prosecution

and professional defrocking—make one thing clear: it is extremely difficult, indeed probably impossible, to distinguish a "partial birth" abortion from the methods of abortion that are conceded to be privileged. (This is the key to the statutes' vagueness, and so a point to which I'll return.) The principal reason for the difficulty is that, as my example of the hydrocephalic fetus suggests, there is no meaningful difference between the forbidden and the privileged practice. No reason of policy or morality that would allow the one would forbid the other. We should consider therefore why any state would pass such a law. An important part of the answer is found in Judge Manion's opinion in *Planned Parenthood of Wisconsin v. Doyle*, 162 F.3d 463 (7th Cir. 1998). The states want to dramatize the ugliness of abortion. "[A]ll methods [of abortion] are gruesome. But this is the one method that has been at least partially exposed to the light of day.... The exposure of this procedure has cast a bright light on the alternative procedures that are equally gruesome.... No doubt when this statute is properly construed—[so] that it bans only the rarely-used D&X procedure—it does not appear to accomplish much in the way of saving babies. But these laws have certainly elevated the public's concern over the fate of the 'potential human lives' that are exposed to abortion." *Id.* at 477, 479 (dissenting opinion). From this standpoint, the more a "partial birth" abortion is like an abortion that is conceded to be constitutionally privileged, the better.

The wave of "partial birth" abortion statutes that broke over the nation after a description of the D&X procedure was publicized—see Martin Haskell, "Dilation and Extraction for Late Second Trimester Abortion" (1992), reprinted in 139 Cong. Rec. E1092, 1993 WL 135664 (Apr. 28, 1993), and in *The Partial-Birth Abortion Ban Act of 1995*, Hearing before the S. Comm. on the Judiciary, 104th Cong., 1st Sess. 5 (Nov. 17, 1995)—does not exhibit the legislative process at its best, whatever one thinks of abortion rights. Whipped up

by activists who wanted to dramatize the ugliness of abortions and deter physicians from performing them, the public support for the laws was also based--as is implicit in Judge Manion's defense of the laws—on sheer ignorance of the medical realities of late-term abortion. The uninformed thought the D&X procedure *gratuitously* cruel, akin to infanticide; they didn't realize that the only difference between it and the methods of late-term abortion that are conceded all round to be constitutionally privileged is which way the fetus's feet are pointing. Opposition to the bills that became these laws was at first muted not only by ignorance of the character of a later-term abortion but also by the fact that few women are likely to be affected by the laws. Circumstances conspired, as it were, to produce a set of laws that can fairly be described as irrational.

This is a harsh verdict, but doubt about its soundness is laid to rest by the absence of any exception for situations in which "partial birth" abortion is necessary to protect the pregnant women's health. The right of abortion is unduly burdened by any law that endangers the woman's health. Even a law that limits only the right to abort viable fetuses—a limitation not found in the statutes challenged in this case—must, to pass constitutional muster, make an exception "for pregnancies which endanger the woman's life *or health*." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, *supra*, 505 U.S. at 846 (emphasis added). Immediately the question arises why the Wisconsin and Illinois legislatures didn't try to come within reach of the cases that permit states to limit the right of abortion by making an exception for pregnancies that endanger the woman's health, the same exception they have written into their other abortion statutes. When pressed at argument, the lawyers for the two states could answer only that the exception is unnecessary. The lawyers were confident that such an abortion is *never* required to preserve a woman's health. They may be right, though I think not (more on this below). But if so, they are

right only for today. Tomorrow, studies may show that, yes, there indeed are cases where a "partial birth" abortion is necessary to protect the mother's health, as many physicians believe. Tomorrow, then, these two statutes may be unconstitutional even by the lights of the majority opinion. Why would a state risk the early obsolescence of its statute by making it wholly dependent on ever-changing medical opinion, when to avoid this risk it need only have excepted those "partial birth" abortions, if any, that are necessary to protect the woman's health? If there are few such cases, the exception will rarely be invoked; if none, never.

The answer is that opponents of abortion do not think there should be an exception for abortions that endanger a woman's health. Life, yes, but not health. These statutes, remember, are not concerned with saving fetuses, with protecting fetuses from a particularly cruel death, with protecting the health of women, with protecting viable fetuses, or with increasing the Wisconsin population (as intimated, surely not seriously, by Wisconsin's counsel). They are concerned with making a statement in an ongoing war for public opinion, though an incidental effect may be to discourage some late-term abortions. The statement is that fetal life is more valuable than women's health.

I do not deny the right of legislatures to enact statutes that are mainly or for that matter entirely designed as a statement of the legislators' values. *Milner v. Apfel*, 148 F.3d 812, 814 (7th Cir. 1998). Nothing in the Constitution forbids legislation so designed. Many statutes are passed or, more commonly, retained merely for their symbolic or aspirational effect. But if a statute burdens constitutional rights and all that can be said on its behalf is that it is the vehicle that legislators have chosen for expressing their hostility to those rights, the burden is undue. The statutes before us endanger pregnant women—and not only pregnant women who *want* to have an abortion. There is no exception for women whose physicians tell them you *must* have an abortion or die. It is

true that if a "partial birth" abortion is necessary to save the woman's life, the statutes permit this. But if her life could be saved by another type of abortion, even one that threatened her health—that threatened to sterilize her or to paralyze her—then the physician would be committing a felony if he performed a "partial birth" abortion. I cannot believe that my colleagues would think the physician could be punished in such a case, and I wonder therefore why the "precautionary" injunctions do not extend to it. The statutes allow a "partial birth" abortion to be performed if "no other medical procedure would suffice for that purpose" (that is, saving the mother's life). Wis. Stat. § 940.16(3); 720 ILCS 513/10. Could not "would suffice" be interpreted to mean "would be as good as from the standpoint of the woman's health"? Such an interpretation, no more audacious than the interpretive leaps that underlie the order to enter "precautionary" injunctions, would seem compelled by the court's own reasoning, but goes unremarked. If the interpretation is rejected, it would imply that a D&X would be forbidden even if the only alternative were a hysterectomy. That can't be right.

The court points out that it is unclear how many women are endangered by these statutes. The forbidden procedure is performed only (or almost only) in late- term abortions, which fortunately are rare; and only in some unknown fraction of them is a "partial birth" abortion the medically preferable procedure. But government cannot without a reason forbid a person to obtain medical treatment and if challenged defend by pointing out that most people don't need that treatment. In the context of abortion this principle is implicit in the statement in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, *supra*, 505 U.S. at 878, that "purpose or effect" (emphasis added)—and thus purpose alone—"to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability" condemns an antiabortion statute. E.g., *Okpalobi v. Foster*,

No. 98-30228, 1999 WL 728396, at *16-20 (5th Cir. Sept.17, 1999); *Jane L. v. Bangerter*, 102 F.3d 1112, 1116-18 (10th Cir. 1996). That is no constitutional novelty; statutes that burden other constitutional rights besides the right of abortion have been invalidated on the basis of improper purpose. E.g., *Edwards v. Aguillard*, 482 U.S. 578 (1987). The *Casey* opinion speaks of placing a substantial obstacle in the path of "a woman," not "many women." Imagine a married woman, pregnant, told by her physician that her life depends on her obtaining an abortion. He tells her it would be better from the standpoint of minimizing the risk to her of medical complications from the abortion for her to have a D&X. But, he adds, unfortunately the law prohibits the procedure. It does so not because the procedure kills the fetus, not because it risks worse complications for the woman than alternative procedures would do, not because it is a crueler or more painful or more disgusting method of terminating a pregnancy, but because the state wishes to make a statement of opposition to constitutional doctrine. A legislature may be taken to intend any consequences of its handiwork that are at once natural, highly probable, and wholly foreseeable (and foreseen). Here the intent is to block a woman from seeking an abortion when her doctor advises her that the best procedure for her is criminal.

The statutes' improper purpose is further shown by the terminology they employ. The Wisconsin statute defines a fetus from the moment of conception to the moment of birth as a "child" (thus absurdly implying that when we are born we are no longer children). The Illinois statute defines the fetus, also from the moment of conception, as an "infant." If these definitions are sound, *all* abortion is infanticide, which is not the Supreme Court's view. A state cannot be permitted to abrogate federal constitutional rights by definition. Line drawing is inescapable but the line between feticide and infanticide is birth. Once the baby emerges from the mother's body, no possible concern for the mother's life or health

justifies killing the baby. But as long as the baby remains within the mother's body, it poses a potential threat to her life or health and this threat presents a compelling case (or so at least the Supreme Court believes) for a right of abortion. The Wisconsin statute, whose provision for life imprisonment already marks it as the crazier one, also allows either of the fetus's grandparents to sue in respect of a "partial birth" abortion. One can imagine a father who cares more for having a grandchild than he cares for the health of his daughter threatening to sue in order to block a "partial birth" abortion, while the mother (who may be divorced from the father), valuing the situation differently, sits on the sideline, helpless to protect her daughter.

In concluding that the challenged statutes do not pose any threat to women's health, the court relies heavily on tendentious factfindings by the district judge in the Wisconsin case. He fastened on the fact that a Dr. Harlan Giles believes that the D&X procedure is rarely, maybe never, necessary for the protection of the pregnant woman's health. The judge brushed aside the contrary testimony of reputable physicians—more reputable, perhaps, as we're about to see, than Dr. Giles. Giles's testimony is essentially the only basis of the judge's finding, and the judge's finding is the principal basis on which this court, disregarding the contrary findings in the Illinois case, dismisses concerns about the absence of a health exception. Yet apart from everything else, Judge Shabaz's opinion is internally contradictory. He acknowledged that the D&X procedure, being quicker and easier to perform on fetuses that are more than 18 weeks old, has advantages for the woman's health in reducing the amount of bleeding, the risk of uterine perforations, and the amount of time that she has to be under anesthesia. *Planned Parenthood v. Doyle*, 44 F. Supp. 2d 975, 979 (W.D.Wis. 1999). Yet without retracting these findings, he concluded that the procedure is never necessary to protect the woman's health.

I daresay reputable physicians can be found who believe that surgery is never necessary in a case of prostate cancer, or that all vitamins are worthless, or that no efforts should be made to resuscitate a person over 80 years old who experiences cardiac arrest, since he is quite likely to be "revived" to a vegetative state. Dr. Giles may not even be wholly reputable. Another district judge rejected his testimony in opposition to the D&X procedure because, among other reasons, Giles was "more focused on the political aspects of the abortion debate than on the medical questions essential to resolution of the issues presented in this action. And, Dr. Giles was evasive when responding to questions directed at crucial issues in the case. Hence the testimony of Dr. Giles was neither credible, reliable nor helpful." *Richmond Medical Center for Women v. Gilmore*, No. Civ. A. 3:98 cv 309, 1999 WL 507453, at *7 (E.D. Va. July 16, 1999) (footnote omitted). Another district judge criticized Giles—who appears to be a member of that much-criticized fraternity, the professional expert witness—for pronouncing on an abortion statute with which he was unfamiliar. *Evans v. Kelley*, 977 F. Supp. 1283, 1309-10 (E.D.Mich. 1997). Another rejected his testimony that the D&X is "a resurrection of an obstetric method discarded in the 1960s, which was used to deliver dead fetuses, and known as craniotomy," and concluded that Giles's criticisms of the D&X procedure were "not persuasive." *Women's Medical Professional Corp. v. Voinovich*, 911 F. Supp. 1051, 1070 (S.D. Ohio 1995), aff'd, 130 F.3d 187 (6th Cir. 1997).

Judge Shabaz, his only support the dubious Dr. Giles, stands alone among district judges who have made fact-findings concerning the potential benefits of the D&X procedure for women's health. See *Rhode Island Medical Society v. Whitehouse*, No. C.A. 97-416L, 1999 WL 683846, at *22 (D. R.I. Aug.30, 1999) (contrary testimony is "unbelievable"); *Richmond Medical Center for Women v. Gilmore*, *supra*, at *44-45; *Carhart v. Stenberg*, 11 F. Supp.

2d 1099, 1124-26 (D. Neb. 1998), aff'd, 1999 WL 753919 (8th Cir. Sept. 24, 1999); *A Choice For Women v. Butterworth*, 54 F. Supp. 2d 1148, 1153, 1156-57 (S.D. Fla. 1998); *Hope Clinic v. Ryan*, 995 F. Supp. 847, 852 (N.D. Ill. 1998) (the decision reversed today without regard for the district judge's findings); *Evans v. Kelley*, *supra*, 977 F. Supp. at 1296; *Women's Medical Professional Corp. v. Voinovich*, *supra*, 911 F. Supp. at 1070; see also *Causeway Medical Suite v. Foster*, 43 F. Supp. 2d 604, 608, 613-14 (E.D. La. 1999); *Planned Parenthood of Central New Jersey v. Verniero*, 41 F. Supp. 2d 478, 484-85 (D. N.J. 1998). If this court is to give weight to district judges' assessment of the credibility of the physicians who have testified pro or con the D&X procedure, it ought at least to acknowledge that Judge Shabaz is in a minority of one.

In refusing to give any weight to the findings of fact made by Judge Kocoras in the *Hope* case, the court seems to have forgotten that we are reviewing his judgment too. It is not some unrelated case that we are free to ignore on the ground that it is based on a different record from any before us. His findings, made in a proceeding that resulted in the issuance of a permanent injunction against the Illinois statute, are entitled to as much weight as Judge Shabaz's, *Knapp v. Northwestern University*, 101 F.3d 473, 478 (7th Cir. 1996); *Durasys, Inc. v. Leyba*, 992 F.2d 1465, 1471 (7th Cir. 1993)—more, really, because they are not infected by the internal contradiction that weakens Judge Shabaz's findings. If those findings justify our upholding the Wisconsin statute, Judge Kocoras's should lead us to invalidate the Illinois statute.

The court denies that Judge Kocoras *made* findings. I don't understand this. It is true that he based his findings on affidavits rather than on live testimony, but the state did not challenge the facts contained in the affidavits, including the facts about the medical advantages of the D&X procedure. Findings do not lose weight by being based on uncontested

facts; admissions are not weaker evidence than facts found after vigorous contest. And if it were true that there were no findings in the Illinois case, this would call for a remand; it would not entitle us to plug Judge Shabaz's findings into a separate litigation with no common parties. (What kind of transplant is *that*?)

Consistent deference to district court factfindings in this pair of cases would lead to an inconsistent result—the upholding of one statute and the condemnation of its sister. This demonstrates that the constitutional right of abortion cannot be made to depend on whether a particular district judge finds a particular physician who disagrees with the consensus of medical opinion to be more credible than the spokesmen for the consensus. The consensus here is found in the statement by the American College of Obstetricians and Gynecologists (ACOG) that the D&X procedure "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision." As Judge Shabaz himself acknowledged, the procedure reduces the risk of lacerating the uterus and the cervix with the sharp instruments used in the standard D&E. Such lacerations cause trauma and loss of blood. The D&X also reduces the risk that fetal tissue will remain in the woman's body, where it can cause infection. It reduces the length of time that the woman is under anesthesia. And it facilitates testing for genetic abnormalities, which is particularly important to the woman's decision whether to become pregnant again. (So much for the suggestion of Wisconsin's lawyer that banning the D&X will lead to more births.) Not all physicians agree with these points; and ACOG hedged its opinion by noting that a select panel of physicians had been unable to identify specific circumstances in which there is no satisfactory alternative to a D&X. But

the team of Dr. Giles and Judge Shabaz are, with all due respect, not competent to resolve this medical controversy.

How often the circumstances sketched in the previous paragraph that led ACOG to recommend retention of the D&X as a treatment option in late-term abortions will be present is not critical. It is slight consolation to be told that while the state has forbidden the optimal treatment of your medical problem, that problem happily is rare. Although we haven't been told of cases in states that have enacted laws forbidding "partial birth" abortion that were not promptly enjoined in which the consequence has been to endanger women, for all we know women in those states go out of state if they are candidates for a D&X. Cf. *Jane L. v. Bangerter*, *supra*, 102 F.3d at 1117. That would be the prudent course. My colleagues in the majority perform their own statistical analysis, outside the record, in an effort to refute this possibility. I have no objection to a court's relying on extra-record evidence to determine the health effects of "partial birth" abortion. Those effects should indeed be treated as a legislative fact rather than an adjudicative fact, in order to avoid inconsistent results arising from the reactions of different district judges, sheltered by the deferential "clear error" standard of appellate review of factfindings, to different records—the inconsistency illustrated by the different findings of Judges Shabaz and Kocoras in the two cases before us. Even so, we should hesitate to play statistician. It is incongruous for this court to brush aside the findings of district judges in other cases while bolstering Judge Shabaz's inadequate findings with extra-record evidence of its own.

The court tries to shore up Judge Shabaz's findings with two medical papers. One of these, however, Nancy G. Romer, "The Medical Facts of Partial-Birth Abortion," 3 *Nexus: A Journal of Opinion* 57 (1998), is not a medical paper at all. Although the author is an M.D., she is also a pro-life activist, and the burden of her paper is that viable fetuses

should be saved rather than aborted. This is a respectable ethical stance but it has nothing to do with the medical pros and cons of a D&X. The other paper, M. LeRoy Sprang & Mark G. Neerhoff, "Rationale for Banning Abortions Late in Pregnancy," 280 *JAMA (Journal of the American Medical Association)* 744 (1998), appears in a section of *JAMA* captioned "controversies," and though it does point out possible dangers to the woman from the procedure, the authors are heavy on the ethical issues involved in abortion. Like Dr. Romer, they come out in opposition to late-term abortion by *any* method, and opine very unscientifically that "partial birth" abortion is "closer to infanticide than it is to abortion." Id. at 746. Another medical article in the same issue of *JAMA* concludes that the D&X procedure should, as ACOG concluded, be an option for the physician. See David A. Grimes, "The Continuing Need for Late Abortions," 280 *JAMA (Journal of the American Medical Association)* 747 (1998). The court does not cite *that* article.

No hypothesis has been proposed by either of the states, or by the *amici curiae* who have submitted briefs in support of the Wisconsin statute, as to why physicians would perform, or the American College of Obstetricians and Gynecologists support, a method of abortion that benefits no patient. There has been no suggestion of any pecuniary incentive that might cause them to engage in a controversial procedure of this kind.

Apart from performing its own statistical analysis and bringing to bear so-called medical papers, the court evinces its queasiness about resting entirely on Judge Shabaz's findings by saying that "the question in the end is not what one or another judge found on a given record" (the question the court had spent so much time discussing). "It is enough that there is real, and not just hypothetical, support for a belief that the partial-birth-abortion laws do not pose hazards for maternal health." This sounds suspiciously like the test for whether a statute has a rational basis, see, e.g., *FCC v.*

Beach Communications, Inc., 508 U.S. 307, 315 (1993), and so may explain the court's one-sided treatment of the facts (the failure to cite Dr. Grimes's paper, for example). Rational basis is not the issue here. The issue is whether the Wisconsin and Illinois "partial birth" statutes impose an undue burden, and specifically whether they are a threat to maternal health. That is rightly an issue of legislative fact, meaning that its resolution is not to be cabined by facts determined in an adjudicative hearing; still it must be resolved in accordance with the weight of the evidence, including such extra-record evidence as the consensus of the relevant expert community, in this case the medical community. It is not enough to note that there is some evidence in support of one side of the issue, when there is more evidence on the other side. In the case the court cites as illustrating the appropriate scope of review, *Craig v. Boren*, 429 U.S. 190, 199-204 (1976), the Supreme Court critically reviewed statistical evidence underlying the claimed constitutionality of the challenged statute—and found it wanting. When one critically reviews the testimony of Dr. Giles, and the court's own statistical analysis, and the so-called medical papers, and weighs them against the evidence that establishes the medical consensus, it becomes apparent that the court does not take the standard of *Craig* seriously.

Let me suggest an analogy. Suppose that a legislature in the South in the 1950s had listened to several "reputable" cognitive psychologists testify that blacks as a group are slow learners, and hence that they should be educated in separate schools. No one would argue that this legislative finding, because supported by *some* evidence from the relevant expert community, would have to be accepted in deciding the constitutionality of segregated education. The court, if it thought the issue relevant, would have to decide whether the finding was correct before relying on it. Similarly, the Wisconsin and Illinois legislatures are not entitled to ban an abortion procedure that the medical community believes may

be preferable from a medical standpoint for some women, simply because a marginally reputable expert (Dr. Giles) thinks that the set of women for whom the procedure is preferable is actually zero. That might bear on the legislatures' good faith (though there is contrary evidence on that too, as I have pointed out), but it would not decide the issue of the statutes' effects on the right of abortion.

Enough said: banning the D&X, the core prohibition in these statutes, imposes an undue burden on women who seek to have an abortion, and is therefore unconstitutional. Let me turn now to the alternative ground of vagueness. Both statutes forbid the partial vaginal delivery of a living fetus, and this describes many instances of the D&E method of abortion—which the court acknowledges cannot constitutionally be banned, see also *Carhart v. Stenberg*, Nos. 98-3245NE, 1999 WL 753919 (8th Cir. Sept.24, 1999); *Little Rock Family Planning Services, P.A. v. Jegley*, No. 99-1004EA, 1999 WL 753928 (8th Cir. Sept.24, 1999); *Planned Parenthood of Greater Iowa, Inc. v. Miller*, No. 99-1372SI, 1999 WL 753770 (8th Cir. Sept.24, 1999)—as well as it does the D&X. Judge Shabaz himself acknowledged that "often" in the course of a D&E there is a fetal heartbeat after portions of the fetus have been delivered into the vagina, 44 F. Supp. 2d at 977, making the D&E definitionally a "partial birth" abortion under both statutes. The court's response, as I noted at the outset of this dissent, is not to hold that the statutes are unconstitutionally vague, but instead to hold that they can't be enforced against any procedure except the D&X until the Wisconsin and Illinois state courts have had a chance (the chance that is unlikely ever to come) to "interpret" their statutes to permit the standard D&E method even when it results, as it frequently does, in the partial vaginal delivery of a living fetus.

Putting to one side my objections to the court's procedure, which I discussed at the outset of this dissent, I note that the court seems to have bought into the legal-realist

view that a statute means whatever the courts say it means, despite the Supreme Court's admonition that a court "may impose a limiting construction on a statute only if it is 'readily susceptible' to such a construction." *Reno v. American Civil Liberties Union*, 521 U.S. 844, 884, 117 S. Ct. 2329, 138 L.Ed.2d 874 (1997), and cases cited there. If the realists are right, and the contrary intimations of cases such as *Reno v. American Civil Liberties Union* can be brushed aside, I wish the court would, as I suggested earlier, hold that these statutes can be further narrowed by "precautionary" injunction to make an exception for cases in which the D&X procedure is necessary to protect the woman's health. The interpolation of such an exception would be no greater act of judicial *hubris* than narrowing the statute to the D&X when the draftsmen of the statutes decided not to use that term, preferring a vaguer term intended to be broader.

The constitutional law of vagueness is obviously in turmoil and so I shall suggest a lowest-common-denominator approach with which I think few judges will disagree, however much they may disagree about its application to particular cases. If a criminal statute is so worded that it is highly likely to condemn a constitutionally privileged act, and if the constitutionally privileged actor could not as a practical matter avoid being punished for engaging in such an act by raising a defense in a criminal proceeding, then the statute is enjoinable, in advance of any prosecutions, as unconstitutionally vague. For the very existence of such a statute "deter[s] constitutionally protected activity." *Coe v. County of Cook*, 162 F.3d 491, 496 (7th Cir. 1998), and cases cited there: When vague statutes prescribe heavy penalties for their violation, rational people avoid any conduct that might be thought to fall within the statute's scope, even if in an error-free litigation the conduct would be sure to be found constitutionally protected. See, e.g., *Village of Hoffman Estates v. The Flipside, Hoffman Estates, Inc.*, *supra*, 455

U.S. at 494 n. 6; *Colautti v. Franklin*, 439 U.S. 379 (1979); *Charles v. Daley*, 749 F.2d 452, 460 (7th Cir. 1984).

When the demanding conditions that I have outlined are satisfied, the statute is invalid, and the legislature has to go back to the drawing board. The court cannot rewrite the statute, or tell the state courts how to rewrite it, and, in advance of any further interpretation, uphold the rewritten statute. That procedure, the procedure followed by the court today, in effect nullifies the doctrine of unconstitutional vagueness.

These statutes are either absurdly (and unlawfully) overbroad or remarkably vague, and the court's direction to issue "precautionary" injunctions is a tacit acknowledgement of its inability to give the statutes a plausible narrowing interpretation; the confused concessions of the states' lawyers at the oral argument were no help in the endeavor. Although the statutes are addressed to physicians—it is their conduct alone that is regulated—the language employed is not medical language. Instead of denoting the victim of illegal abortion as a live fetus, a fetus with a heartbeat, or a viable fetus (a fetus, remember, that can survive outside the mother's body), the Illinois statutes refers to "a living human fetus or infant," terms that the statute explains are "used interchangeably to refer to the biological offspring of human parents," 720 ILCS 513/5, while the Wisconsin statute refers to "a living child" or "partially delivered child," with "child" defined, as I noted earlier, as "a human being from the time of fertilization until it is completely delivered from a pregnant woman." Wis. Stat. §§ 940.16(1)(a), (b). The use of such language makes the statutes incurably ambiguous. Neither "biological offspring" nor "living" is defined. At argument the Solicitor General of Illinois was emphatic that "biological offspring" is a synonym for "intact fetus," that is, a fetus (however deformed) before the physician performing the abortion begins to work on it. But he retreated from this position when faced with the hypothetical case of a physician

who, intending to perform a D&X, removes a limb or other part of the fetus before beginning the procedure. His retraction was consistent with his statement that the Illinois legislature had tried to make the statute "as broad as possible." More extensive dismemberment than merely removing a limb or two, Wisconsin's lawyer assured us, would inevitably kill the fetus before any part of it emerged from the uterus. She offered no basis for this hopeful bit of medical advice, and it is wrong. *Carhart v. Stenberg*, *supra*, at *4; *Richmond Medical Center for Women v. Gilmore*, *supra*, at *10. By "killing" the fetus, she evidently meant doing something to cause its heart to stop beating, although a fetus is living before it develops a heart. Obviously a one-day old embryo, like the cells that compose a living human body, is alive, not "dead."

In a standard D&E, part or all of the fetus often will still have a heartbeat, and so be "living," in the sense of the word apparently intended by the legislatures, when it emerges from the uterus. Therefore it is "partially vaginally delivered," just as in a D&X. "During the D&E procedure, the fetus may be removed from the uterus and brought through the cervix and vagina either intact or disarticulated.... [I]t may happen that part of the intact fetus will be in the vagina and part in the uterus or a disarticulated part of the fetus will be in the vagina while the remainder of the fetus is in the uterus. In either of these situations, that part of the fetus which remains in the uterus may still have a heartbeat." *Planned Parenthood of Central New Jersey v. Verniero, supra*, 41 F. Supp. 2d at 484. If the physician then kills the fetus, he would, one would think, be guilty of having violated these statutes, which punish the killing of a fetus that has been partially vaginally delivered.

Against this interpretation, the Illinois Solicitor General, discarding settled principles of criminal law for the sake of a short-term victory, declared that the statute would not be violated unless the physician had *planned* before beginning

the abortion to wait until a part of the fetus had emerged from the uterus and kill the fetus then; the mere fact that the physician knew it was likely that a part of the fetus would be outside the uterus at the moment of death would not show the requisite intent. By this logic—which the state's Solicitor General actually embraced at argument—if you fire a machine gun into a lighted college dormitory at night, reckoning that you have only a 10 percent chance of actually killing anyone, and you do kill one or more of the residents, you are not guilty of murder, provided you didn't want to kill anyone but just wanted to see whether your machine gun was in working order. The law is otherwise. First-degree murder in Illinois requires only that "in performing the acts which cause the death" the defendant "knows that such acts create a strong probability of death or great bodily harm." 720 ILCS 5/9-1; *People v. Daniels*, 702 N.E.2d 324, 330-31 (Ill.App. 1998); *People v. Mitchell*, 601 N.E.2d 916, 919 (Ill.App. 1992); *Hennon v. Cooper*, 109 F.3d 330, 333-334 (7th Cir. 1997). A physician who performs a standard D&E knowing, as he must, before he begins, that part of the fetus is quite likely to be outside the uterus when he kills the fetus, and then kills it after a part has emerged from the uterus, is guilty of the crime of partially vaginally delivering a living fetus and then killing it.

The Illinois statute itself, moreover, requires only that the partial-birth abortion have been performed "knowingly." 720 ILCS 513/10. Under the law of Illinois, a defendant is deemed to know "the result of his conduct, described by the statute defining the offense, when he is consciously aware that such result is practically certain to be caused by his conduct." 720 ILCS 5/4- 5(b).

Wisconsin authorizes life imprisonment for performing a "partial birth" abortion. That is the state's heaviest penalty, the penalty for murder. Wisconsin deems its statute—as both the penalty and the use of the term "child" to denote the fetus reflect—a law against infanticide. (So does Illinois, by using

the term "infant," but it is not serious, because the maximum punishment for killing the "infant" is only three years.) No one would suppose, in the example of shooting into a dormitory, that if only a one-day-old baby were killed the killer would be innocent of murder. If Wisconsin is serious in regarding a fetus that has begun to emerge from the uterus as "a living child" who should be protected to the full extent of the law against murder, it cannot rationally interpret the statute to permit the physician to escape punishment by the plea that when he began the abortion he thought there was only a 50 percent chance that he would be killing "a living child." It would be like arguing that if a nurse hit a newborn over the head with a baseball bat, with all her might, not to kill it but merely to make it stop crying, and the newborn died, the nurse could defend against a charge of first- degree murder by proving that while she thought it quite possible that the newborn would die, she didn't want it to die and thought it had a 50 percent chance of surviving.

Any doubts on this score are stilled by Wisconsin's statutory definition of intentional. The statute punishes "intentionally" performing a partial birth abortion, Wis. Stat. § 940.16(2), and the term means either acting purposely to accomplish the forbidden end or being "aware that [one's] conduct is practically certain to cause that result." Wis. Stat. § 939.23(3). As glossed by the case law, the alternative definition is satisfied by conduct carrying a known high risk of the forbidden result even if that result is not desired. See *State v. Gould*, 202 N.W.2d 903, 906 (Wis. 1973); *State v. McCarter*, 153 N.W.2d 527, 529 (Wis. 1967); *State v. Webster*, 538 N.W.2d 810 (Wis.App. 1995). In *Webster*, where the defendant was convicted of attempted first-degree murder, it was deemed irrelevant that the jury might have accepted his testimony "that he precisely aimed the shotgun at Hood's armpit, and that the gun was loaded only with shotshells filled with bird shot." 538 N.W.2d at 815.

So the state-of-mind requirements of the two statutes turn out to be the same. They are, moreover, the standard state of mind requirements for liability for serious crimes. A criminal defendant acts intentionally, and, even more clearly, knowingly, "when he knows that that result [here, a 'partial birth' abortion] is practically certain to follow from his conduct, whatever his desire may be as to that result." 1 Wayne R. LaFave & Austin W. Scott, Jr., *Substantive Criminal Law* § 3.5, p. 304 (1986); see, e.g., *United States v. United States Gypsum Co.*, 438 U.S. 422, 444-46 (1978); *Smith v. Farley*, 59 F.3d 659, 663 (7th Cir. 1995); *United States v. McAnally*, 666 F.2d 1116, 1119 (7th Cir. 1981).

I have discussed the state of mind requirements of these statutes at such length in order to make clear how little mileage the court can get from the cases that it cites, such as *Screws v. United States*, 325 U.S. 91 (1945), that save vague statutes by narrow interpretations. Put aside the fact that these were federal statutes given narrowing interpretations by federal courts, rather than state statutes given narrowing interpretations by federal courts, and that the Supreme Court in *Bellotti v. Baird*, 428 U.S. 132, 146-47 (1976), a decision that is still good law on this point, held that the proper way to obtain a narrowing interpretation of a vague state abortion statute is to abstain in favor of the state courts. The point I wish to stress is that the device used in *Screws* and many similar cases to save the statute, that of interpolating a *scienter* requirement, is unavailable here. And this for two reasons. The first is that the Wisconsin and Illinois statutes make clear what the state of mind requirement for guilt under each statute is, leaving no room for interpolating such a requirement in the guise of interpretation; and the second is that the problem with knowing what these statutes require of a physician is not ignorance of legal obligation, but ignorance of the factual premises of liability. The statute challenged in *Screws* made it a crime to deprive a person of a constitutional right. The Court held that the statute could be saved by

requiring that the defendant be shown to have *known* that he was violating a constitutional right. It was a realistic requirement because the set of constitutional rights at any moment is more or less known and it is a straightforward (though not always easily answerable) factual question whether the defendant knew that his conduct infringed something in that set. No one knows what procedures constitute "partial birth" abortion, and specifically whether many, perhaps most, D&E's do, given that the fetus often has a heartbeat after part of the fetus has emerged from the uterus. *Screws*, when he beat his victim to death, knew that he was committing the assault; the question was whether he knew that the assault (because he was a sheriff and his victim an arrestee) violated the Constitution. Physicians performing late-term abortions in Illinois and Wisconsin do not know whether they are performing "partial birth" abortions and thus committing crimes.

The incurable vagueness of these statutes might seem to be of little moment if a physician prosecuted for infanticide or feticide had a sure defense should the prosecution stray beyond the narrow path to which the court today attempts to confine the statute. He could not avoid prosecution but at least he would know he would be acquitted, and if he were lucky he would be let out on bail pending trial and maybe Planned Parenthood would pay his legal fees. But let us be realistic, and not only about the possibility of legal error. The physician is not the real target of the statute; the pregnant woman is. It is not the physician's pregnancy that is to be terminated. He has no incentive to undergo the agony of a criminal prosecution merely in order to perform an abortion in a particular way. Better for him either to abandon late-term abortions altogether, or to be sure to give the fetus a lethal injection in utero, and wait for it to take effect, before performing the abortion. The *in terrorem* effect of these statutes, especially the Wisconsin statute with its maximum penalty of life imprisonment, is likely to induce physicians in

these states to steer well clear of the forbidden zone. What physician would be fool enough, or hero enough, to risk a criminal prosecution in order to explore the precise meaning and outer bounds of the precautionary injunctions that this court has ordered the district courts in these two cases to enter, even if the risk is small?

And now we can see more clearly one of the fallacies in the "precautionary" injunction gimmick. It is the existence of these statutes, because of their extraordinary breadth and the limited incentive of a physician to test their scope, not the risk of prosecution, which may indeed be slight, that burdens those abortion rights that are conceded to be constitutionally protected. A peculiarity of abortion rights is that they require the assistance of a third party, the physician, who has a lesser interest in them than his patient. Because his interest is less, he is more easily deterred, and this should increase our concern with the deterrent effects of these vague statutes.

It remains only to make clear that in finding these statutes pernicious and unconstitutional I do not mean to criticize anyone who believes, whether because of religious conviction, nonsectarian moral conviction, or simply a prudential belief that upholding the sacredness of human life whatever the circumstances is necessary to prevent us from sliding into barbarism, that abortion is always wrong and perhaps particularly so in late pregnancy, since *all* methods of late-term abortion are gruesome. If a woman told by her physician that her fetus will be a Down's baby or a Tay-Sachs baby or will be born without arms or legs, or that her own health or even life will be endangered if she carries the fetus to term, decides nevertheless against abortion, I would be the last to criticize her decision. I might consider her a heroine or a saint. But what is at stake in these cases is whether the people who feel that way are entitled to coerce a woman who feels differently to behave as they would in her situation. The Constitution as interpreted by the Supreme Court in decisions that we are not free to palter with answers

this question "no." We should therefore affirm the district court's decision in *Hope* and reverse the district court's decision in *Doyle*.

A true Copy:

Teste:

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Clerk of the United States Court of Appeals for the Seventh Circuit

United States Court of Appeals

For the Seventh Circuit
Chicago, Illinois 60604

CORRECTED JUDGMENT
WITH ORAL ARGUMENT

Corrected Date: November 1, 1999

BEFORE: Honorable RICHARD A. POSNER, Chief Judge
Honorable JOHN L. COFFEY, Circuit Judge
Honorable JOEL M. FLAUM, Circuit Judge
Honorable FRANK H. EASTERBROOK, Circuit Judge
Honorable DANIEL A. MANION, Circuit Judge
Honorable MICHAEL S. KANNE, Circuit Judge
Honorable ILANA DIAMOND ROVNER, Circuit Judge
Honorable TERENCE T. EVANS, Circuit Judge

No. 98-1726

HOPE CLINIC, MARILYNN C. FREDERIKSEN, M.D., NORMAN A. GINSBERG, M.D., et al.,
Plaintiffs-Appellees

v.

JAMES E. RYAN, Attorney General of the State of Illinois, in his official capacity and RICHARD K. DEVINE, State Attorney for Cook County, in his official capacity,
Defendants-Appellants

Appeal for the United States District Court for the Northern District of Illinois, Eastern Division.
No. 97 C 8702, Charles P. Kocoras, Judge

Nos. 99-2528 & 99-2533

DENNIS D. CHRISTENSEN, et al.,
Plaintiffs-Appellants

v.

JAMES E. DOYLE, Attorney General of Wisconsin, and DIANE M. NICKS, District Attorney for Dane County, Wisconsin,
Defendants-Appellees

Appeals from the United States District Court for the Western District of Wisconsin.
No. 98 C 0305, John C. Shabaz, Chief Judge

Nos. 98-1726, 99-2528 & 99-2533

The judgments in both cases are VACATED. The cases are REMANDED with instructions to enter the precautionary injunction discussed in Part II.3 of this opinion, to dismiss the challenges to the civil-liability provisions for want of a case or controversy, and otherwise to enter judgment for the defendants. The above is in accordance with the decision of this court entered on October 26, 1999. Defendants recover costs in both cases.

Circuit Judge Ripple did not participate in the consideration or decision of these cases.

(1182-110894)

United States Court of Appeals

For the Seventh Circuit
Chicago, Illinois 60604

November 17, 1999

By the Court:

THE HOPE CLINIC, et al., Plaintiffs-Appellees	)	Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.
No. 98-1726 v.	)	
JAMES R. RYAN, Attorney General of the State of Illinois, and RICHARD K. DEVINE, State's Attorney of Cook County, Illinois Defendants-Appellants	)	No. 97 C 8702 Charles P. Kocoras, *Judge*
DENNIS D. CHRISTENSEN, et al. Plaintiffs-Appellants,	)	Appeals from the United States District Court for the Western District of Wisconsin.
Nos. 99-2528 & 99-2533 v.	)	
JAMES E. DOYLE, Attorney General of Wisconsin, and DIANE M. NICKS, District Attorney for Dane County, Wisconsin, Defendants-Appellees.	)	No. 98-c-0305-S John C. Shabaz, *Judge*.

Order

Plaintiffs' motions for stay of mandate, referred to the full court, are denied. Because the constitutionality of the statutes has been sustained by this court after plenary review, the states are entitled to enforce their statutes. The precautionary injunctions required by the court's ruling should prevent any irreparable harm while plaintiffs seek review by the Supreme Court.

Circuit Judges Ripple and Williams did not participate in the consideration or decision of these motions.

DIANE P. WOOD, *Circuit Judge,* with whom POSNER, *Chief Judge,* and ROVNER and EVANS, *Circuit Judges,* join, dissenting from the order denying the stay of the mandate. Displaying a regrettable disregard for the importance of the issues implicated in these two cases, the split in views about their proper disposition not only within this court but around the country, and the inadequacy of the injunctions that the opinion in these cases contemplates, a majority of judges on this court have voted to deny plaintiffs' motions for a stay of the mandates pending the Supreme Court's consideration of their petitions for certiorari. This kind of tactic does nothing to assist the orderly presentation of fundamental constitutional questions to the highest court in our country. Furthermore, as I explain briefly below, the "precautionary injunctions" that the majority has ordered the district courts to enter (which of course have not yet been drafted, nor tested in any court of law) are by design insufficient to prevent irreparable harm while the plaintiffs pursue their remedies in the Supreme Court. I therefore dissent from the court's decision to deny the requested stay of the mandates.

By asserting that the planned "precautionary injunctions" will be enough to forestall irreparable harm, the majority has assumed the answer to some of the very questions that will be put before the Supreme Court in the petitions for certiorari.

In so doing, it has misunderstood the perspective we should adopt at this final stage of proceedings in the court of appeals. When we consider a stay of our mandate to allow the Supreme Court to act, we are no longer acting as a single circuit. The question is instead how the views of the majority of this circuit's judges correspond to the views expressed by other courts around the country. That is the context in which we should measure the risk of irreparable harm, and from that standpoint, it is considerable. We are dealing, after all, with matters of life and death, as they relate to a woman's exercise of a constitutional right the Supreme Court has repeatedly recognized. See, e.g., *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992); *Roe v. Wade*, 410 U.S. 113, (1973). Even the majority cannot dispute the fact that the circuits are divided on the question whether statutes like the Illinois and Wisconsin laws are constitutional. The "precautionary" injunctions that the district courts are expected to enter on remand from this court will do nothing to ameliorate much of that risk. The contemplated injunctions will not add a "health" exception to the Wisconsin and Illinois statutes, and apart from the one doctor on whom the majority in our court has relied, a great number of respectable physicians (including the American College of Obstetricians and Gynecologists, or ACOG) believe that a health exception is necessary. If the majority's medical prediction turns out to be wrong and ACOG is right, some women in this region of the country may find their health permanently impaired even with the "precautionary" injunctions in place.

In addition, as Chief Judge Posner's dissenting opinion explains at greater length, there are many who will be unable to draw a sensible line between the D&E procedure that the "precautionary" injunctions, once drafted, will allegedly find some way to protect, and the D&X procedure that they will permit the states to prohibit (on pain of life imprisonment in Wisconsin, it is worth remembering, lesser imprisonment in

Illinois, and potential loss of professional license in both places.) Saying that the line can be drawn is not the same thing as drawing it, no matter what *scienter* standards the majority has articulated. The doctors, who have little personally to gain from donning a legal hat and guessing how close to the line they dare go, and everything to lose, will inevitably take a conservative approach that will burden the constitutional rights of their patients. This is the rationale that underlay the positions of the Sixth and Eighth Circuits. See *Carhart v. Stenberg*, 1999 WL 753919, *6-9 (8th Cir. Sept. 24, 1999); *Little Rock Family Planning Services, P.A. v. Jegley*, 1999 WL 753928, *4 (8th Cir. Sept. 24, 1999); *Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187, 197-200 (6th Cir. 1997). Indeed, the Eighth Circuit thought it so clear that wording essentially identical to that found in our two statutes prohibited the D&E procedure that it seems not to have found the statutes before it vague at all, which is why it proceeded to the undue burden analysis. See *Planned Parenthood of Greater Iowa, Inc., v. Miller*, 1999 WL 753770, *2 (8th Cir. Sept. 24, 1999).

In my view, the only responsible action this court can take from the standpoint of its national responsibility and role is to stay the mandates pending the Supreme Court's disposition of the petitions for certiorari. Should the Court decide not to hear these cases, implementation of the majority's conclusions will be delayed by only four to six months. If, however, the Court grants the petitions in these cases, or grants in one of the other pending cases and holds these on its docket, that means it has concluded that the cases are indeed of extraordinary national importance. The lack of harm from a grant of the requested stay, the risk of irreparable injury from its denial, and our responsibility to preserve the status quo for the Supreme Court, all demonstrate how ill-advised the majority's action today is. I respectfully dissent from the denial of the motions for the stay of the mandates.

United States Court of Appeals

For the Seventh Circuit
Chicago, Illinois 60604

November 30, 1999

By the Court:

THE HOPE CLINIC, et al.,
Plaintiffs-Appellees

No. 98-1726 v.

JAMES R. RYAN, Attorney General of the State of Illinois, and RICHARD K. DEVINE, State's Attorney of Cook County, Illinois
Defendants-Appellants

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.

No. 97 C 8702
Charles P. Kocoras, *Judge*

DENNIS D. CHRISTENSEN, et al.,
Plaintiffs-Appellants,

Nos. 99-2528 & 99-2533 v.

JAMES E. DOYLE, Attorney General of Wisconsin, and DIANE M. NICKS, District Attorney for Dane County, Wisconsin,
Defendants-Appellees.

Appeals from the United States District Court for the Western District of Wisconsin.

No. 98-c-0305-S
John C. Shabaz, *Judge*.

Order

The motions for stays of mandate are denied by an equally divided court. By majority vote, pursuant to Fed. R. App. P. 41(b), the court has determined that the mandates will issue on December 1, 1999.

Circuit Judge Ripple did not participate in the consideration or decision of these cases.

DIANE P. WOOD, *Circuit Judge*, with whom POSNER, *Chief Judge*, and ROVNER, EVANS and WILLIAMS, *Circuit Judges*, join, dissenting from the order denying the stay of the mandate. Displaying a regrettable disregard for the importance of the issues implicated in these two cases, the split in views about their proper disposition not only within this court but around the country, and the inadequacy of the injunctions that the opinion in these cases contemplates, five members of this court have voted to deny plaintiffs' motions for a stay of the mandates pending the Supreme Court's consideration of their petitions for certiorari. Five other members of the court have voted to grant the requested stay. The even split means that there is no majority in favor of the stay, which means in turn that the mandates will issue on the date specified in the order being issued today. The insistence of five members of the court on immediate implementation of the decision does nothing to assist the orderly presentation of fundamental constitutional questions to the highest court in our country. Furthermore, as I explain briefly below, the "precautionary injunctions" that the majority's merits opinion directs the district courts to enter (which of course have not yet been drafted, nor tested in any court of law) are by design insufficient to prevent irreparable harm while the plaintiffs pursue their remedies in the Supreme Court. I therefore dissent from the court's decision to deny the requested stay of the mandates.

By asserting that the planned "precautionary injunctions" will be enough to forestall irreparable harm, those who think the stays should be denied have assumed the answer to some of the very questions that will be put before the Supreme Court in the petitions for certiorari. In so doing, they have misunderstood the perspective we should adopt at this final stage of proceedings in the court of appeals. When we consider a stay of our mandate to allow the Supreme Court to act, we are no longer acting as a single circuit. The question is instead how the views of this circuit's judges correspond to the views expressed by other courts around the country. That is the context in which we should measure the risk of irreparable harm, and from that standpoint, it is considerable. We are dealing, after all, with matters of life and death, as they relate to a woman's exercise of a constitutional right the Supreme Court has repeatedly recognized. See, *e.g.*, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992); *Roe v. Wade*, 410 U.S. 113, (1973). Even the stay opponents cannot dispute the fact that the circuits are divided on the question whether statutes like the Illinois and Wisconsin laws are constitutional. The "precautionary" injunctions that the district courts are expected to enter on remand from this court will do nothing to ameliorate much of that risk. The contemplated injunctions will not add a "health" exception to the Wisconsin and Illinois statutes, and apart from the one doctor on whom the merits majority relied, a great number of respectable physicians (including the American College of Obstetricians and Gynecologists, or ACOG) believe that a health exception is necessary. If the majority's medical prediction turns out to be wrong and ACOG is right, some women in this region of the country may find their health permanently impaired even with the "precautionary" injunctions in place.

There is another problem as well with the "precautionary" injunctions, which is the fact that they do not even exist right

now. For reasons explained in its merits opinion, the majority thinks that there is enough danger of improper enforcement of both statutes to warrant the extraordinary step of directing the issuance of the injunctions. But that process may take weeks, or even months, leaving a legal void in the meantime during which the states will be utterly unconstrained. Even if the Attorneys General themselves can be counted on not to abuse their position during this lacuna, the same cannot be said for all prosecutors. Law enforcement in both states is decentralized, carried out by local prosecutors who are independently elected officials. Particularly during the time period while local prosecutors are not legally compelled to decipher whatever precautionary injunction is entered, some may decide to prosecute abortion providers who perform D&E procedures that literally conform to the statutory definition of a "partial-birth abortion," which the majority concedes are constitutionally protected. No doubt the probability of such prosecutions is small, but, given the fact that we are talking about a total of 174 independent county prosecutors in the two states, it is just as real as the risk (also assumed by the majority to be small) that led to the precautionary injunctions to begin with.

In addition, as Chief Judge Posner's opinion dissenting on the merits clearly explains, there are many who will be unable to draw a sensible line between the D&E procedure that the "precautionary" injunctions, once drafted, will allegedly find some way to protect, and the D&X procedure that they will permit the states to prohibit (on pain of life imprisonment in Wisconsin, it is worth remembering, lesser imprisonment in Illinois, and potential loss of professional license in both places). Saying that the line can be drawn is not the same thing as drawing it, no matter what *scienter* standards the majority has articulated. The doctors, who have little personally to gain from donning a legal hat and guessing how close to the line they dare go, and everything to lose, will inevitably take a conservative approach that will

burden the constitutional rights of their patients. This is the rationale that underlay the positions of the Sixth and Eighth Circuits. See *Carhart v. Stenberg*, 1999 WL 753919, *6-9 (8th Cir. Sept. 24, 1999); *Little Rock Family Planning Services, P.A. v. Jegley*, 1999 WL 753928, *4 (8th Cir. Sept. 24, 1999); *Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187, 197-200 (6th Cir. 1997). Indeed, the Eighth Circuit thought it so clear that wording essentially identical to that found in our two statutes prohibited the D&E procedure that it seems not to have found the statutes before it vague at all, which is why it proceeded to the undue burden analysis. See *Planned Parenthood of Greater Iowa, Inc., v. Miller*, 1999 WL 753770, *2 (8th Cir. Sept. 24, 1999).

In my view, the only responsible action this court can take from the standpoint of its national responsibility and role is to stay the mandates pending the Supreme Court's disposition of the petitions for certiorari. I note in this connection that counsel for the Attorney General of Wisconsin, in her response to the plaintiffs' motion, informed this court on November 18, 1999, that the defendants-appellees in *Christensen* do not oppose the requested stay. Although that notification reached the court after its November 17, 1999, order denying the stay, it is now properly before us, and it tells us in plain language that Wisconsin believes that the orderly course of proceedings-which, it is worth recalling, is a different question from the merits-will be furthered, or at least not harmed, by the stay. Should the Supreme Court decide not to hear these cases, implementation of the majority's conclusions will be delayed by at most four to six months. If, however, the Court grants the petitions in these cases, or grants in one of the other pending cases and holds these on its docket, that means it has concluded that the cases are indeed of extraordinary national importance. The lack of harm from a grant of the requested stay (recall that both state laws have been on hold throughout the pendency of this litigation), the risk of irreparable injury

to both women and their doctors from its denial, and our responsibility to preserve the status quo for the Supreme Court, all demonstrate how ill-advised the action by this equally divided court truly is. I respectfully dissent from the denial of the motions for the stay of the mandates.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

THE HOPE CLINIC, MARILYNN CONNERS FREDERIKSEN, M.D., NORMAN A. GINSBERG, M.D., CASSING HAMMOND, M.D., LAUREN STREICHER, M.D., DAVID ZBARAZ, M.D., et al.,	)	
Plaintiffs,	)	
v.	)	97 C 8702
JAMES RYAN, Attorney General of the State of Illinois, in his official capacity; RICHARD DEVINE, State Attorney for Cook County, in his official capacity,	)	
Defendants.	)	

MEMORANDUM OPINION

CHARLES P. KOCORAS, District Judge:

Plaintiffs, the Hope Clinic and several doctors, bring this action against defendants, the Attorney General of the State of Illinois and the State's Attorney for Cook County, in their official capacities, pursuant to 42 U.S.C. §§ 1983 and 1988, and pursuant to 28 U.S.C. §§ 2201 and 2202. Plaintiffs seek declaratory and injunctive relief from this court to prevent House Bill 382 ("HB 382"), the Partial-Birth Abortion Ban Act (the "Act"), from taking effect on February 13, 1998.

This Act imposes criminal and civil penalties against individuals who perform "partial-birth abortions". Plaintiffs challenge the constitutionality of the Act on the grounds that it is vague and unduly burdensome in violation of the Due Process Clause of the Fourteenth Amendment and that it endangers the health and life of women in violation of the Equal Protection Clause of the Fourteenth Amendment.

This matter is before the court on the plaintiffs' motion for a preliminary and permanent injunction. Plaintiffs assert that an injunction is necessary to prevent irreparable harm to themselves and their patients from the statute's chilling effect on their ability to provide abortion services. Plaintiffs contend that they can demonstrate actual success on the merits of their claims by proving that the Act is facially vague and unduly burdensome on a woman's right to seek an abortion. In addition, they assert that injunctive relief will serve the public interest in that it will protect the constitutional rights of women.

Twenty-five years after the Supreme Court's decision in Roe v. Wade, 410 U.S. 113, 93 S. Ct. 705, 35 L.Ed.2d 147, this country is still deeply divided over whether a woman should have the right to terminate her pregnancy and the extent of that right. Although the abortion issue divides people on moral, religious and political grounds, this court is bound to resolve questions on the extent of a woman's constitutional right to an abortion on legal grounds. The court has reviewed the parties' briefs, the affidavits and declarations from plaintiffs' experts, and Supreme Court authority. For the reasons set forth below, the court grants the plaintiffs' motion for a preliminary and permanent injunction. Before addressing the merits of the plaintiffs' motion, the court will identify the parties to this dispute, outline the challenged legislation, and describe the abortion procedures used in Illinois that may be within the legislation's reach.

I. THE PARTIES

The parties in this action are as follows. The Hope Clinic for Women, Ltd., provides abortions and abortion-related services including testing, non-directive options counseling and post-abortion birth control services, in Granite City, Illinois. The Hope Clinic provides abortions to women from the fifth week to the twenty-fourth week of pregnancy as measured from the woman's last menstrual period ("LMP").

The remaining plaintiffs are physicians licensed to practice in the State of Illinois. Plaintiff Marilynn Conners Frederiksen, M.D., is the Section Head for General Obstetrics and Gynecology at Northwestern Memorial Hospital. She is an Associate Professor in Obstetrics and Gynecology and in Clinical Pharmacology at Northwestern University Medical School in Chicago. She has been certified by the American Board of Obstetrics and Gynecology as a Maternal-Fetal Medicine Specialist. Moreover, Dr. Frederiksen is a Diplomate of the Board. Dr. Frederiksen provides a number of services to her patients including prenatal care, fetal diagnoses, labor and delivery, fetal therapy and abortion usually between six and twenty-four weeks LMP.

Plaintiff Norman A. Ginsberg, M.D., is an Assistant Professor of Clinical Obstetrics and Gynecology at Northwestern University Medical School. He is a Diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Obstetrics and Gynecology. Dr. Ginsberg is a founding member of the International Society of Obstetrical and Gynecological Ultrasound, a member of the Society of Perinatal Obstetricians, and holds an Affiliate Doctoral from the American College of Medical Genetics. He is a member of the American Medical Association and the International Fetal Medicine and Surgery Society. Dr. Ginsberg also serves on the Editorial Board of the Journal of Reproduction and

Genetics. Dr. Ginsberg provides abortions until twenty-four weeks LMP.

Plaintiff Cassing Hammond, M.D., is an Instructor of Obstetrics and Gynecology at Northwestern University Medical School, and actively engages in the practice of obstetrics and gynecology, including providing abortion services. Dr. Hammond is a Fellow of the American College of Obstetrics and Gynecology and a member of the Association of Professors of Gynecology and Obstetrics.

Plaintiff Lauren Streicher, M.D., provides a broad range of services including, gynecological care, pre-natal care, labor and delivery, and abortion. She is a Clinical Instructor of Obstetrics and Gynecology at Northwestern University Medical School. Dr. Streicher is a Diplomate of the American Board of Obstetrics and Gynecology and her admission to become a Fellow of the American College of Obstetrics and Gynecology is pending. Dr. Streicher serves on the Early Detection Committee of the American Cancer Society, Illinois Division, and the Medical Board of Planned Parenthood of Chicago.

Plaintiff David Zbaraz, M.D., is a Clinical Assistant Professor of Obstetrics and Gynecology at Northwestern School of Medicine. He is a Diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Obstetrics and Gynecology. Dr. Zbaraz is also a member of the American Medical Association, the Illinois State Medical Society and the Chicago Medical Society. Dr. Zbaraz provides a broad range of services, including prenatal care, fetal diagnoses, labor and delivery, and abortion.

The plaintiffs bring this suit individually and as a class action on behalf of all duly licensed physicians, surgeons and medical researchers desiring to perform or conduct medical research relating to pregnancy terminations, patients seeking abortion services, and minors capable of giving informed consent to an abortion procedure or whose best interests

would be served by an abortion. Plaintiffs bring suit against defendant James Ryan, Attorney General for the State of Illinois, in his official capacity, and against defendant Richard Devine, State's Attorney for Cook County, in his official capacity.

II. THE CHALLENGED LEGISLATION

HB 382 bans "partial-birth abortions". A "partial-birth abortion" is defined as "an abortion in which the person performing the abortion partially vaginally delivers a living human fetus or infant before killing the fetus or infant and completing the delivery." The terms "fetus" and "infant" are defined as the "biological offspring of human parents." The phrase "partially vaginally delivers" is not defined in the statute, nor are the terms "deliver" or "living".

The ban does not apply to a partial-birth abortion that is necessary "to save the life of a mother because her life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering condition caused by or arising from the pregnancy itself, provided that no other medical procedure would suffice for that purpose." There is no exception to the ban in circumstances when the woman's health is endangered, when the woman suffers from conditions or illnesses other than those enumerated, such as mental conditions or disorders, or when the woman's health is endangered by the pregnancy itself or is compromised by the alternative abortion procedure. Finally, the Act does not make a distinction as to the viability of the fetus.

The Act also provides that a person who "knowingly" performs a partial-birth abortion is guilty of a Class 4 felony. The penalty for a Class 4 felony is imprisonment for not less than one year and for as many as three years, and includes a fine of as much as $10,000. 730 ILCS 5/5 §§ 5-8-1(a)(7), 5-9-1(a)(1). A physician convicted of a felony risks having her license revoked or suspended by the Department of

Professional Education and Registration. 225 ILCS 60/22 (A)(3). In addition, a physician who violates the Act may be subject to civil suits by the "maternal grandparents of the fetus" if the mother is under the age of 18 years at the time of the abortion and the plaintiff did not consent to the procedure. There is an exception to such civil suits if the pregnancy of the minor resulted from the plaintiff's criminal conduct. Physicians subject to these civil suits may be liable for money damages for all psychological and physical injuries resulting from the partial-birth abortion, and statutory damages equal to three times the cost of the partial-birth abortion.

III. ABORTION PROCEDURES

In order to properly understand the parties' arguments as to the breadth and vagueness of the Act, it is necessary to understand the various abortion procedures utilized by physicians in Illinois. The court's description of these procedures is taken from the affidavits and declarations of the five named plaintiffs and the affidavits of Julie R. Adams and Beth A. Fine, M.S., C.G.C., who provide counseling to women seeking abortions and have specialized knowledge of the circumstances under which women seek abortions. Plaintiffs have moved this court to qualify the plaintiff-physicians, Adams, and Fine as experts. Defendants do not object to this motion or to the medical opinions and facts contained in the affidavits, but have objected to portions of the affidavits that they claim contain legal conclusions and speculation, or lack foundation.

A district court has broad discretion to admit or rely on expert testimony. See Miksis v. Howard, 106 F.3d 754, 762 (7th Cir. 1997). Expert testimony is admissible if "scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue." Fed. R. Evid. 702. Moreover, experts are permitted

to testify as to the ultimate issue in a case. Moore v. Wesbar Corp., 701 F.2d 1247, 1253 (7th Cir. 1983). In this case, the court will rely on the statements made by the physician-plaintiffs in their affidavits and declarations as to the various abortion procedures used, the reasons women obtain abortions, their understanding of the ban on partial-birth abortions, and its effect on their practice. For these reasons, we grant the plaintiffs' motion for qualification of experts inasmuch as these matters are within the scope of their established expertise.

Abortion is one of the safest surgical procedures in terms of mortality and morbidity, and it is much safer than continuing the pregnancy through childbirth. In the first trimester of pregnancy, when most abortions are performed, a woman is twenty times more likely to die from continuing the pregnancy through childbirth than from a first-trimester abortion. At any stage of pregnancy, a woman is ten times more likely to die from continuing the pregnancy through childbirth than from an abortion. The risk of death from abortion, however, increases approximately 30% with each week of gestation from eight weeks LMP to twenty weeks LMP. The risk of major complications increases approximately 20% with each week of gestation from seven weeks onward. When performing an abortion, the physician chooses the procedure most appropriate for a particular patient. This decision is based on a number of variables, including the underlying health conditions of the patient, the stage of pregnancy, the condition of the fetus, the position of the fetus, the skill and training of the physician, and the facilities available.

The term "partial-birth" abortion is not a medical term and does not denote a specific abortion procedure. Rather, the doctors described six abortion procedures: (1) administration of agents such as RU 486 and methotrexate, for early first-trimester abortions; (2) suction curettage; (3) dilation and evacuation procedures ("D&E"); (4) induction

procedures; (5) hysterotomy; and (6) hysterectomy. Because RU 486 and methotrexate are not available in the United States except as part of clinical trials, the court will not address them in the context of the partial-birth abortion statute.

A. Suction Curettage

For first-trimester abortions, most physicians in Illinois use suction curettage, also called vacuum aspiration. In this procedure, the physician mechanically dilates the cervix and then removes the embryo or fetus and the other products of conception with a tube or syringe that is inserted in the uterus. The tube is attached to a vacuum generator, which provides suction to empty the contents of the uterus. During the procedure, the fetus can come through the suction tube either intact or dismembered. While dismembered parts of the fetus are suctioned out of the uterus, part of the fetus remains in utero and may be "alive," which the experts define as having a heartbeat.

B. D&E

At the end of the first-trimester and thereafter, most physicians generally use either the D&E procedure, which accounts for 95% of post-first trimester abortions nationally, or induction, which accounts for 5% of such abortions. In a D&E procedure, a physician begins by dilating the cervix over a period of hours with multiple intracervical osmotic dilators, which absorb moisture and expand slowly in the cervix. When the cervix is sufficiently dilated, the physician removes the dilators and ruptures the amniotic sac. Then, using a combination of suction curettage and forceps, the physician removes the fetus. The fetus is usually removed in parts, but at times, the physician can remove the fetus intact. Because the calvarium (skull) is often too large to pass

through the cervix whole, the physician must either collapse it with forceps or use suction to remove the calvarium's contents. A number of factors affect the progression of this procedure, including the size and orientation of the fetus, the amount of dilation, the condition of the cervix and uterus, and the patient's overall health and medical condition. The physician adapts her technique in light of the individual patient's needs.

Physicians sometimes use a variation of this procedure, particularly in the late second-trimester, referred to as the intact D&E or the D&X. In an intact D&E, the physician extracts the fetus intact, feet first, until the cervix is obstructed by the fetal skull. Because the fetal skull is too large to pass through the cervix, it must be decompressed either with forceps or by inserting a sharp instrument at the base of the fetal skull and evacuating the contents. The intact D&E is particularly useful in cases of fetal abnormalities because geneticists often request that the fetus be removed intact to facilitate genetic testing. In addition, the intact D&E reduces the risk of retained tissue and reduces the risk of uterine perforation and cervical laceration because the procedure requires less instrumentation in the uterus. An intact D&E may also result in less blood loss and less trauma for some patients and may take less operating time.

The D&E procedures are particularly important for women whose fetuses have genetic or congenital anomalies. Some of these anomalies are fatal within days, or even minutes, of birth. Because most fetal anomalies cannot be detected before the sixteenth to eighteenth week LMP, and the results of these tests do not come back until two to four weeks after the test was taken, the D&E procedures are extremely important because they can be used to terminate these pregnancies safely. Another advantage of the D&E procedures is that they entail lower rates of maternal health complications, including fever, endometritis, retained products of conception, hemorrhage, and cervical injury. The

safety of the D&E depends upon the skill and training of the physician because the procedure involves the use of sharp instruments inside the uterus.

C. Induction

Another method of performing second-trimester abortions is to administer medications that induce premature labor. Inductions generally are not done before sixteen weeks LMP because prior to that point, the uterus is less responsive to labor-inducing medications. Inductions are performed in a hospital or hospital-like setting by using a combinations of the following: intravenous injection of oxytocin, continuously over many hours; introduction of prostaglandins into the vagina or cervix; insertion or laminaria into the cervix; and instillation of urea in the amniotic sac, by injection through the abdomen. Sometimes a separate procedure is necessary to remove the placenta and other remaining products of conception. During some inductions, the umbilical cord may become entangled and the physician must cut it to complete the delivery. In rare instances when the fetus is still alive, cutting the cord can cause fetal death in six to ten minutes.

Inductions are medically inappropriate for some women, such as women with cardiac conditions, active pelvic infections, or when the woman has had a previous hysterotomy or classical caesarean section. Because high doses of labor-inducing medications are used in inductions, severe metabolic disturbances and fatal heart, lung and kidney conditions may also result. Complications associated with full-dose saline instillation can result in hemorrhage in all major organs including the brain. Prostaglandin instillation can cause cervical trauma, severe gastrointestinal side-effects, infection, hemorrhage and sudden death. Certain types of inductions are also contraindicated for women with sickle cell anemia, hypertension, kidney disease,

epilepsy, asthma, certain types of glaucoma, and pulmonary hypertension.

There are a number of disadvantages associated with inductions as compared to D&E procedures. Inductions take longer than D&Es, require hospital stays, are costly, and entail levels of pain and trauma similar to the levels experienced during labor and delivery at full-term. Moreover, the maternal mortality rate of induction procedures is almost twice that of D&E procedures, although the rates are comparable for post-sixteen week procedures. Compared to inductions, D&E procedures have lower rates of maternal health complications, including fever, endometritis, retained products of conception, hemorrhage and cervical injury. Another advantage of D&Es over induction procedures is that D&Es can be performed in the earliest weeks of the second-trimester while inductions are generally not effective until the sixteenth week LMP. Thus, inductions require a woman to delay her abortion, thereby increasing the risks involved. On the other hand, inductions have a lower rate of uterine perforation than the rate of such perforations when D&E procedures are used.

D. Hysterotomy and Hysterectomy

Many years ago, hysterotomy and hysterectomy were used to terminate second-trimester pregnancies. A hysterotomy is essentially a pre-term caesarian section. The physician makes an incision in the uterine wall and removes the fetus, through the abdomen. Women who have had hysterotomies are at significantly greater risk of uterine rupture in subsequent pregnancies. Uterine rupture can be associated with catastrophic bleeding. Hysterectomy is the removal of the uterus and renders the woman sterile. Hysterectomy entails greater surgical risk and prolonged recovery time. Both procedures entail major abdominal surgery with risks far greater than the other abortion methods

described. The mortality rate associated with hysterotomy and hysterectomy is more than seven times that associated with instillation abortion and more than ten times that associated with D&E procedures. The experts agree that these two procedures are almost never medically appropriate.

IV. LEGAL STANDARD FOR INJUNCTIVE RELIEF

Plaintiffs seek a preliminary and permanent injunction from this court to prevent defendants from enforcing HB 382, the Partial-Birth Abortion Ban Act. This court must consider four traditional criteria in deciding whether to grant preliminary injunctive relief: (1) whether the plaintiffs have a reasonable likelihood of success on the merits; (2) whether the plaintiffs have an adequate remedy at law or will be irreparably harmed if the injunction does not issue; (3) whether the injury to the plaintiffs from denying injunctive relief outweighs the harm to the defendants from granting the injunction; and (4) whether the public interest will be served by granting the injunction. Plummer v. American Institute of Certified Public Accountants, 97 F.3d 220, 229 (7th Cir. 1996) (citing N.L.R.B. v. Electro-Voice, Inc., 83 F.3d 1559, 1567 (7th Cir. 1996), cert. denied, --U.S.-- 683, 117 S.Ct. 683, 136 L.Ed.2d 608 (1997)).

The standard for a permanent injunction is essentially the same as for a preliminary injunction except that in seeking a permanent injunction, a plaintiff must prove actual success on the merits rather than a likelihood of success on the merits. Amoco Production Co. v. Village of Gambell, 480 U.S. 531, 546 n. 12, 107 S. Ct. 1396, 1404 n. 12, 94 L.Ed.2d 542 (1987). Moreover, a permanent injunction is not provisional in nature but rather, it is a final judgment. Plummer, 97 F.3d at 229 (citing Walgreen Co. v. Sara Creek Property Co., 966 F.2d 273, 275 (7th Cir. 1992)). With these principles in mind, we begin our substantive review of the statute.

V. DISCUSSION

As stated above, plaintiffs must show actual success on the merits of their claim that HB 382 is unconstitutional. Plaintiffs offer three reasons for declaring the statute unconstitutional: (1) the statute is vague; (2) the statute unduly burdens the constitutional rights of women seeking abortions; and (3) the statute impermissibly requires third-party consent from the parents of a minor seeking an abortion.

A. Vagueness

"It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined." Grayned v. City of Rockford, 408 U.S. 104, 108, 92 S. Ct. 2294, 2298, 33 L.Ed.2d 222 (1972). Due process demands that statutes give fair warning as to the conduct that is prohibited. Id. Without such warning as to the meaning of a statute, people will "steer far wider of the unlawful zone ... than if the boundaries of the forbidden areas were clearly marked." Id. at 109 (quoting Baggett v. Bullitt, 377 U.S. 360, 372, 84 S. Ct. 1316, 1322-23, 12 L.Ed.2d 377 (1964)). A statute, therefore, is void for vagueness if people of "ordinary intelligence" are forced to guess at the meaning of the statute and differ as to its application. See Grayned, 408 U.S. at 108; Smith v. Goguen, 415 U.S. 566, 574, 94 S.Ct. 1242, 1248, 39 L.Ed.2d 605 (1974). Moreover, a statute is void for vagueness if it "impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an ad hoc and subjective basis, with attendant dangers of arbitrary and discriminatory application." Grayned, 408 U.S. at 109, 92 S. Ct. at 2299.

Perhaps the most important factor affecting the clarity that the Constitution demands of a law is whether it threatens

to inhibit the exercise of constitutionally protected rights. Village of Hoffman Estates v. Flipside, Hoffman Estates Inc., 455 U.S. 489, 499, 102 S. Ct. 1186, 1193, 71 L.Ed.2d 362 (1982); Colautti v. Franklin, 439 U.S. 379, 391, 99 S. Ct. 675, 683, 58 L.Ed.2d 596 (1979). Moreover, the standard of certainty that due process requires is higher when a statute imposes criminal penalties. Kolender v. Lawson, 461 U.S. 352, 358 n. 8, 103 S. Ct. 1855, 1859 n. 8, 75 L.Ed.2d 903 (1983). Failure to satisfy the more stringent standard in cases where constitutional rights or criminal penalties are involved necessitates a finding that the law is unconstitutionally vague. Evans v. Kelley, 977 F. Supp. 1283, 1304 (E.D.Mich. 1997) (citing Kolender, supra). This is true even though the law could conceivably have some constitutional applications. Colautti, 439 U.S. at 391, 99 S. Ct. at 683; Kolender, 461 U.S. at 358, 103 S. Ct. at 1859. With these principles in mind, we review HB 382.

HB 382 bans "partial-birth abortions". A "partial-birth abortion" is defined as an abortion in which the physician "partially vaginally delivers" a "living" fetus before killing the fetus and completing the delivery. The phrase "partially vaginally delivers" is not defined in the statute. The term "living" is also not defined in the statute. Because persons of ordinary intelligence are forced to guess as to the meaning of the phrase "partially vaginally delivers" and the term "living," the court must find the statute void for vagueness. The statute simply does not provide fair notice to individuals who are subject to the statute as to the conduct that is prohibited.

The phrase "partially vaginally deliver" is subject to more than one interpretation. The term "deliver" or "delivery" is given a broad meaning in obstetrics. Anything that is removed from the uterus, whether it is a fetus, a fetal part, or a baby, is "delivered." Thus, in every abortion procedure, except hysterotomy and hysterectomy, a fetus or a fetal part is "delivered." Given this broad meaning of the term

"delivery," the phrase "partially vaginally delivers" can encompass two distinct situations. On the one hand, "partially vaginally delivers" may describe a situation where an intact fetus is delivered in part through the uterus. On the other hand, "partially vaginally delivers" may describe a situation where part of a fetus is delivered through the uterus. See Ginsberg Affidavit, ¶ 16; Hammond Declaration, ¶ 27; Zbaraz Affidavit, ¶ 15.

The term "living" also has more than one meaning and may be interpreted differently by people of "ordinary intelligence". One dictionary defines "living" as "possessing life; alive." THE AMERICAN HERITAGE DICTIONARY 737 (2d College ed. 1982). The term "life" is defined as "[t]he property or quality that distinguishes living organisms from dead organisms ... manifested in functions such as metabolism, growth, response to stimuli, and reproduction." Id. at 728. The term "life" can also signify "[t]he interval of time between birth and death." Id. Physicians define the term "living" as "having a heartbeat." The physicians' definition, therefore, extends the dictionary definition to a time before birth. As such, their definition encompasses situations where fetal parts have been "delivered" but the remaining part continues to have a heartbeat. Without a clear definition in the statute as to the meaning of the term "living," a physician cannot know whether her conduct falls within the statute's reach.

In almost every abortion procedure, with the exception of hysterotomy and hysterectomy, either a delivery of a partial fetus or a partial delivery of an intact fetus may occur. In a suction curettage procedure, a tube is inserted in the uterus and fetal parts are evacuated through the cervix and into the vaginal canal. While these parts are being evacuated, other parts of the fetus remain in the uterus. These remaining parts may be "living" if there is a heartbeat. When this happens, the physician may have "partially vaginally delivered" a "living" fetus. In D&E procedures, the physician removes

the fetus with forceps and suction curettage. In so doing, a physician may "deliver" or "partially deliver" an intact, living fetus or a part of a "living" fetus that continues to have a heartbeat. In either instance, the physician may have performed a "partial-birth abortion" as defined in HB 382. Frederiksen Decl. ¶ 50; Ginsberg Aff. ¶ 17; Hammond Decl. ¶ 27; Zbaraz Aff. ¶ 15. When beginning a suction curettage procedure or a D&E procedure, a physician cannot predict whether a part of a fetus or an intact fetus will be "delivered," or whether a part of the fetus with a heartbeat will remain in the uterus.

The phrase "partially vaginally delivers" may also encompass some cases of induction and cases where a woman spontaneously aborts her fetus. In some cases of induction, the umbilical cord becomes entangled and must be cut by the physician in order to complete the delivery. In those rare instances when the fetus is still "alive," cutting the cord may cause its death within six to ten minutes. In completing the delivery during this time period, the physician may have "partially vaginally deliver[ed]" a living fetus. Hammond Decl. ¶ 28; Zbaraz Aff. ¶ 16; Ginsberg Aff. ¶ 18. In addition, in cases where a woman spontaneously aborts, it may be in her best interests for the physician to complete the abortion. Again, part of the "living" fetus may remain in the cervical os while other fetal parts are "delivered" by the physician. Hammond Declaration, ¶¶ 30-33.

The phrase "partially vaginally delivers" is undefined, ambiguous and subject to more than one interpretation. Likewise, the terms "living" and "delivery" are undefined and subject to more than one interpretation. The law's drafters may have intended to define these terms in a way that differs from the medical definition of such terms. Physicians cannot determine whether the legislature intended to ban a specific practice or entire abortion procedures. As such, they will steer far wider of the unlawful zone and refuse to perform many abortion procedures even if those

procedures are not proscribed by the statute. Defendants argue that common-sense dictates that the legislature intended to proscribe situations in which an intact, living fetus is partially or entirely brought out of the uterus and into the birth canal. However, when people of ordinary intelligence are confused as to the statute's meaning and differ as to the interpretation of the statute, common-sense dictates that the statute is unclear and ill-defined.[1] This is especially the case when the people whose conduct is directly implicated by the statute cannot discern the statute's meaning and its application.

Our decision that the Partial-Birth Abortion Ban Act is void for vagueness finds support in this circuit. In Charles v. Carey, 627 F.2d 772, 790-91 (7th Cir. 1980), the Seventh Circuit held that an abortion statute was void for vagueness because it left terms undefined yet subjected physicians to stiff criminal penalties. The challenged statute expanded the definition of term "individual" in the Illinois Criminal Code to include "any human being aborted alive." Thus, any person who killed an "individual" or a "human being aborted

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[1] The defendants attempt to clarify HB 382 by asserting that the term "birth" as used in "partial-birth abortion" is defined in one medical text as "the process by which a liveborn infant or stillborn infant is expelled or extracted from the mother." It is this scenario that defendants claim the statute proscribes. The statute, however, contains a different definition for the phrase "partial-birth" abortion. As used in HB 382, the term "birth" is part of the phrase "partial-birth abortion", which is defined as "an abortion in which a person ... partially vaginally delivers a living human fetus or infant before killing the fetus or infant and completing the delivery." We refuse to read another definition into the statute when the term at issue is already defined within the statute. It is from the definitions within the statute that we draw the statute's meaning.

alive" could be guilty of murder under the Illinois Criminal Code. The Seventh Circuit enjoined the statute because it found that the phrase "any human being aborted alive" failed to give fair notice of the conduct that was forbidden. The court explained:

> The meaning of the term "alive" could include only the most minimal of life signs in a nonviable fetus or it could be limited to the capability of sustained survival. The lack of a precise definition leaves physicians uninformed as to their duties toward the fetus and could deter them from performing abortions for fear of being singled out for prosecution for murder under this ambiguous standard.

627 F.2d at 791. Likewise, in the statute before this court, the term "living" could describe the most minimal life signs in a nonviable fetus, such as having a heartbeat, or it could mean capable of sustained survival. However, the court, and more importantly, the physicians, have no way of knowing whether the legislature intended the statute to apply to the former situation rather than the latter.

District courts in other circuits that have been confronted with similar "partial-birth abortion statutes" have found the language of the statute, or lack thereof, ambiguous and susceptible to more than one interpretation. For example, in Evans v. Kelley, 977 F. Supp. 1283 (E.D.Mich. 1997), the court declared the partial-birth abortion statute at issue void for vagueness. The statute in Evans defined "partial-birth abortion" as an abortion in which the physician "partially vaginally delivers a living fetus before killing the fetus and completing the delivery." Similarly, in Planned Parenthood of Southern Arizona, Inc. v. Woods, 982 F. Supp. 1369 (D. Ariz. 1997), the district court held the partial-birth abortion

statute unconstitutionally vague because its definition was ambiguous and susceptible to different interpretations. Like HB 382, the Arizona law defined "partial-birth abortion" as a procedure in which a physician "partially vaginally delivers a living fetus."

Because the constitutional rights of women are directly affected by the interpretation of the statute taken by physicians who perform abortion procedures, defendants must meet a higher standard of certainty to avoid a vagueness problem. A higher standard of certainty is also required because criminal penalties are imposed by the statute. Defendants have failed to meet such a standard. The statute, laden with undefined terms, fails to define with any certainty the conduct that is proscribed. Without such definitions to guide persons as to the prohibited conduct, the law "furnishes a convenient tool for 'harsh and discriminatory enforcement by ... prosecuting officials'," Papachristou v. City of Jacksonville, 405 U.S. 156, 170, 92 S. Ct. 839, 847, 31 L.Ed.2d 110 (1972) (quoting Thornhill v. State of Alabama, 310 U.S. 88, 97-98, 60 S. Ct. 736, 742, 84 L.Ed. 1093 (1940)), and gives law enforcement officers, courts and jurors "unfettered freedom" to "engage in arbitrary and discriminatory enforcement." Id. As such, the court finds that the statute is void for vagueness. This holding, in turn, renders the entire statute unconstitutional as the remainder of the statute depends upon the vague provisions for its meaning.

B. Undue Burden

Plaintiffs also contend that HB 382 is unconstitutional because it imposes an undue burden on the constitutional rights of women seeking abortions. In Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 112 S. Ct. 2791, 120 L.Ed.2d 674 (1992), the Supreme Court reaffirmed the central holding of Roe v. Wade, 410 U.S. 113,

93 S. Ct. 705, 35 L.Ed.2d 147 (1973), that a woman has a constitutional right to terminate her pregnancy before viability and the State may not prohibit any woman from making that ultimate decision. The Court also reaffirmed Roe's holding that "subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." Casey, 505 U.S. at 879, 112 S. Ct. at 2821 (quoting Roe, 410 U.S. at 164-65, 93 S. Ct. at 732).

The plurality, however, rejected Roe's rigid trimester framework because they believed it undervalued the State's interest in life. Under the trimester framework, almost all abortion regulations were prohibited during the first trimester of pregnancy. During the second trimester, regulations were permitted to protect the woman's health, but not to further the State's interest in potential life. During the third trimester, laws regulating or prohibiting abortion were allowed provided that the life or health of the mother was not at stake. Instead of this framework, the plurality in Casey drew the line at viability and recognized the State's interest in promoting life even in the earliest stages of pregnancy. The Court declared: "Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause." 505 U.S. at 874, 112 S. Ct. at 2819. In the Courts view, "the undue burden standard is the appropriate means of reconciling the State's interest with the woman's constitutionally protected right." 505 U.S. at 876, 112 S. Ct. at 2820.

The Court clarified that a state regulation imposes an undue burden when it has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. 505 U.S. at 877, 112 S. Ct. at 2820. "A statute with this purpose is invalid because the

means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it." Id. Moreover, the Court stated that state regulations that promote the health or safety of a woman seeking an abortion are valid, unless they have the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion.

Applying these principles, we review the challenged legislation. HB 382 proscribes "partial-birth abortions" except in cases where it is necessary to save the life of the mother because her life is endangered by a physical disorder, a physical illness, or a physical injury, including a life-endangering condition caused by the pregnancy itself, "provided that no other medical procedure would suffice for that purpose." There is no exception to the ban when the woman's health is endangered, when the woman suffers from conditions or illnesses other than those enumerated, such as mental condition or disorders, or when the woman's health is endangered by the pregnancy itself or is compromised by the alternative abortion procedure. Significantly, the Act does not distinguish between abortions that are performed before viability and after viability.

For two reasons, the court finds that HB 382 imposes an undue burden on a woman's constitutional right to choose to terminate her pregnancy before viability. First, the statute, as written, has the potential effect of banning the most common and safest abortion procedures. It does so without regard for the viability of the fetus. Second, the statute does not permit a physician to use the prohibited procedure when it is necessary to protect the woman's health, whether mental or physical, or when an alternative abortion procedure would compromise the woman's health. As such, HB 382 is clearly unconstitutional.

HB 382 has the potential effect of banning the most common and safest abortion procedures. It prohibits physicians from "knowingly" performing a partial-birth

abortion. Although "knowingly" is not defined by the statute, it generally means "consciously" or when a person "acts with awareness of the nature of his conduct." BLACK'S LAW DICTIONARY 872 (6th ed. 1990). Thus, a physician acts "knowingly" when she is aware that her conduct may fall within the statute's reach. In virtually every abortion procedure, except hysterotomy and hysterectomy, a physician may "knowingly" violate HB 382. As explained before, in suction curettage, D&E, and induction procedures, a physician is aware that she may deliver a partial "living" fetus or partially deliver an intact fetus. Although the physician does not know in advance whether one of these two scenarios will in fact occur, she will have violated the statute when such a delivery occurs. To ensure that her conduct does not fall within the statute's reach, the physician will probably stop performing such procedures.

The affidavits and declarations submitted by the plaintiff-physicians supports this conclusion. All of the physicians stated in their affidavits and declarations that if HB 382 goes into effect, they and their colleagues will most likely stop performing abortions because they "know" that during any abortion procedure, except hysterotomy and hysterectomy, a part of a "living" fetus may be delivered or an intact fetus may be partially delivered. Although they cannot predict in advance whether this will happen, they will stop performing abortions to avoid criminal and civil punishment. See Ginsberg Aff. ¶ 17 ("a doctor cannot predict whether such a circumstance will arise, but there is always a possibility that it will."); Streicher Aff. ¶ 5; Frederiksen Decl. ¶ 5; Hammond Decl. ¶¶ 27, 28. Dr. Zbaraz states that "[b]ecause physicians cannot predict the precise course of events that will occur in a given abortion procedure," it is his belief that "the mere performance of a procedure deemed after the fact to fall within HB 382's definition" could subject him to criminal penalties. This risk of prosecution "would cause [him] to stop providing abortions." Zbaraz Aff. ¶ 17.

Likewise, Dr. Frederiksen states that because "the course of surgery and obstetrical practice is unpredictable," a physician cannot adhere to a rigid plan, but must adapt quickly and proceed in a way that may not have been intended at the outset of the procedure. Frederiksen Decl. ¶ 52. In her opinion, "HB 382 leaves physicians to fear that virtually any abortion could subject them to criminal liability." Id. at ¶ 53. Because the standard in HB 382 effectively chills physicians from performing most abortion procedures, the statute is an undue burden on a woman's constitutional right to seek an abortion before viability.

Moreover, physicians who want to continue performing abortion procedures will have to do so at an increased cost or an increased risk to the patient. See Streicher Aff. ¶ 5; Frederiksen Decl. ¶ 5. According to Dr. Zbaraz, if physicians stop performing suction curettage, D&E and induction procedures, they will be limited to performing hysterotomies, hysterectomies and induction procedures that ensure the demise of the fetus in utero. Zbaraz Aff. ¶ 21. The mortality rate associated with hysterotomy and hysterectomy is more than ten times that associated with a D&E procedure and more than seven times that associated with instillation abortion. Moreover, the mortality rate of induction procedures is almost twice that of D&E procedures. Serious complications, including fatal heart, liver and kidney problems, can result from performing inductions, hysterotomies and hysterectomies. Hysterectomies also render a woman sterile. Thus, the health risk to women will be significantly higher if D&E and suction curettage procedures are prohibited and only hysterotomy, hysterectomy, and induction procedures are available.

Further, because these procedures require hospital stays and expensive equipment, the cost of abortion procedures to patients will significantly increase. Ginsberg Aff. ¶ 23. Whereas D&E procedures cost from $350 to $700, inductions and other procedures that require hospital stays cost from

$1000 to $3000. Frederiksen Decl. ¶ 54. Such procedures often require expensive ultrasound equipment, costing in excess of $30,000. Because HB 382 will significantly increase the cost of abortion procedures, it places a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. Such an undue burden on her constitutional rights is unconstitutional.

Alternatively, a physician could avoid the reach of HB 382 by assuring the demise of the fetus in utero. To do so, a physician would have to inject the fetus prior to beginning the abortion procedure with a substance to trigger cardiac arrest. Zbaraz Aff. ¶ 23, Ginsberg Aff. ¶ 24. However, only a few physicians are trained to perform such injections and they require the use of highly sophisticated ultrasound machinery. Hammond Decl. ¶ 40; Ginsberg Aff. ¶ 24. These injections are also contraindicated for some women, such as those who have heart conditions. They also carry a risk of puncturing the bowel, veins or arteries. Zbaraz Aff. ¶ 23. A punctured bowel can result in a serious infection and possibly death. Punctured veins or arteries can cause internal bleeding. Another way to ensure fetal demise is to attempt to cut the umbilical cord while the fetus is in utero. Depending on the location of the cord within the uterus, searching for the cord with an instrument or suction tube can cause uterine perforation and other complications. Hammond Decl. ¶ 42. On the other hand, suction curettage and D&E procedures have significantly lowered the risk and improved the overall quality of second trimester abortion procedures. Zbaraz Aff. ¶ 21; Ginsberg Aff. ¶ 21. Hysterotomy, hysterectomy and induction procedures that ensure fetal demise cannot be regarded as effective substitutes for suction curettage and D&E procedures.

In Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 75-79, 96 S. Ct. 2831, 49 L.Ed.2d 788 (1976), the Supreme Court found unconstitutional a provision of a Missouri abortion statute that prohibited the use of saline

amniocentesis, an abortion procedure used after the first 12 weeks of pregnancy. The appellants in Danforth argued that this proscription would effectively preclude abortions after the first trimester because 70% of all abortions performed after the first trimester used the proscribed procedure. Moreover, they stressed that hysterotomy and hysterectomy were significantly more dangerous, and another safer alternative, prostaglandin installation, was not widely used. The Court relied upon these arguments in finding the proscription unconstitutional. The Court stated:

> [T]he State ... would prohibit the use of a method which the record shows is the one most commonly used nationally by physicians after the first trimester and which is safer, with respect to maternal mortality, than even the continuation of pregnancy until normal childbirth. Moreover, ... it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed.

428 U.S. at 78-79, 96 S. Ct. at 2845. The Court found that the ban on the procedure was not "a reasonable regulation for the protection of maternal health." Rather, it was "an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks." Id. The Court, therefore, held that the ban on the procedure was unconstitutional. See also Wynn v. Scott, 449 F. Supp. 1302, 1325-26 (N.D.Ill. 1978) (finding a statute's proscription of an abortion procedure unconstitutional where alternative procedures available were not as safe and were contraindicated for certain women), aff'd sub nom. Wynn v. Carey, 599 F.2d 193 (7th Cir. 1979).

Other circuit and district courts that have reviewed similar partial-birth abortion statutes have found that the effect of such statutes would be to prevent many women from obtaining safe abortions. See, e.g., Women's Medical Professional Corp. v. Voinovich, 130 F.3d 187 (6th Cir. 1997); Evans v. Kelley, 977 F. Supp. 1283 (E.D.Mich. 1997); Planned Parenthood of Southern Arizona, Inc. v. Woods, 982 F. Supp. 1369 (D. Ariz. 1997); Carhart v. Stenberg, 972 F. Supp. 507 (D.Neb. 1997). Under Carey and Danforth, this effect is unconstitutional and renders the statute invalid. Because HB 382 has the effect of inhibiting the vast majority of abortion procedures and would significantly increase the health risks for a woman seeking an abortion of a nonviable fetus, the court finds the statute unconstitutional.

Defendants contend that there are applications of HB 382 that would unquestionably be constitutional. For example, they argue that a physician who aborts a viable, full-term, partially-born child for no compelling reason relating to maternal health would be subject to prosecution under the statute. Under these circumstances, they claim that the statute would operate constitutionally. Defendants ask that we apply the standard set forth in United States v. Salerno, 481 U.S. 739, 745, 107 S. Ct. 2095, 2100, 95 L.Ed.2d 697 (1987), which was decided five years before the Supreme Court's decision in Casey. Under Salerno, to make a facial challenge to a statute, "the challenger must establish that no set of circumstances exists under which the Act would be valid." Id. The fact that the statute "might operate unconstitutionally under some conceivable set of circumstances is insufficient to render it wholly invalid." Id.

It appears, however, that the plurality in Casey abandoned the Salerno rule in cases dealing with abortion. The plurality in Casey rejected the State's argument that although the spousal consent provision at issue imposed a burden on some women, it imposed almost no burden on the vast majority of women seeking abortions. 505 U.S. at 894,

112 S. Ct. at 2829. Circumstances, therefore, existed where the statute operated within constitutional bounds. In rejecting this argument, the plurality stated:

> The analysis does not end with the one percent of women upon whom the statute operates; it begins there. Legislation is measured for consistency with the Constitution by its impact on those whose conduct it affects..... The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant.

Id. Because the statute would impose an undue burden on the small percentage of married women who did not want to tell their husbands about the abortion, the plurality held that the statute was invalid and unconstitutional.

It should be noted that Chief Justice Rehnquist acknowledged the plurality's decision to forego application of the Salerno rule in his dissent, joined by Justice White, Justice Scalia and Justice Thomas. The Chief Justice stated that it was not enough for the petitioners to show that in some cases the spousal consent provision would operate in an unconstitutional manner. Instead, under Salerno, "they must 'show that no set of circumstances exists under which the [provision] would be valid.'" 505 U.S. at 973, 112 S. Ct. at 2870 (Rehnquist, C.J., dissenting) (citations omitted). The Chief Justice went on to say that the plurality "appears to ignore this point in concluding that the spousal notice provision imposes an undue burden ....". 505 U.S. at 973 n. 2, 112 S. Ct. at 2870 n. 2.

We are bound to follow the plurality's decision and must apply the undue burden standard as set out in Casey. Applying Casey, the proper focus for our inquiry is the group for whom the law is a restriction, namely the vast majority of

women who seek abortions of a nonviable fetus. Defendants would have us focus on the group for whom the law is irrelevant, i.e. those who seek abortion of a viable fetus. The law is irrelevant for such a group because Illinois already proscribes abortions after viability when health concerns are not at issue. See 720 ILCS 510/5. It would be totally superfluous for the Illinois legislature to pass a statute that applied only to women seeking abortions of a viable fetus when another statute already covers such circumstances. Instead, it is clear that the Illinois legislature passed a statute that was meant to proscribe much broader conduct. The statute, as written, cannot withstand constitutional scrutiny.

Even if the court found that there are alternative procedures available to women seeking abortions of a nonviable fetus, the statute would nevertheless be invalid because it does not provide an exception to the ban when the woman's health, whether it be mental or physical health, is endangered, or when the alternative procedure would compromise her health. This failure to include a health exception also renders the statute unconstitutional. Without a health exception, the statute places a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability. See Casey, 505 U.S. at 878, 112 S. Ct. at 2821.

A woman seeks an abortion for many reasons, including the fact that a pregnancy may compromise her health or subject her to serious medical problems. Medical and surgical illnesses, whether caused by the pregnancy or pre-existing but complicated by the pregnancy, may necessitate that the physician advise the woman to consider an abortion. Frederiksen Aff. ¶ 15. These illnesses and conditions include: anemia and other diseases of blood, urinary tract infections and disease, acute renal failure, heart disease, endocrine disorders, diseases of the nervous system, liver diseases, connective tissue disorders such as lupus erythematosus and rheumatoid arthritis, and HIV. Some of

these illnesses and disorders can be exacerbated by the pregnancy and become more painful due to the pregnancy. Pregnancy and the process of delivering a baby may prove fatal to a woman with a serious illness or disease. Id. In these circumstances, a woman may want an abortion before the fetus becomes viable.

If, however, HB 382 went into effect, women could not have "partial-birth abortions" when only their health is in danger. Instead, they would have to undergo either hysterotomy, hysterectomy, and inductions in which fetal demise is ensured, unless one of these procedures puts their lives at risk. As stated before, these procedures entail significant health risks, even as much of a risk as the pregnancy itself presents. A woman would be forced to make an untenable choice between either undergoing a risky abortion procedure or continuing her pregnancy in the face of unknown risks and health concerns. Further, the statute does not permit a physician to use the banned procedure when the alternative procedures endanger the patient's health or exacerbate her existing health conditions. The statute forces the physician to advise her patient in a manner that may be contrary to the patient's best interests. Such an interference into the rights of women seeking abortions is unacceptable under Casey. Before viability, a woman has a constitutional right "to choose to have an abortion and to obtain it without undue interference from the State." Casey, 505 U.S. at 846, 112 S. Ct. at 2803. Even subsequent to viability, Casey reaffirmed that "the State ... may ... regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgement, for the preservation of the ... health of the mother." 505 U.S. at 879, 112 S. Ct. at 2821 (quoting Roe, 410 U.S. at 164-65, 93 S. Ct. at 732). Without a health exception, HB 382 is unconstitutional.

The lack of a health exception in HB 382 also indicates that the Illinois legislature intended to "trade-off" the woman's health for fetal survival. That is, the statute only

permits abortion procedures that are extremely risky to the woman and prohibits the safer alternatives, unless her life is in danger. The purpose and effect of such a statute is to force women to carry their fetuses to full-term. Such a trade-off between a woman's health and fetal survival was held unconstitutional in Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 768-69, 106 S. Ct. 2169, 90 L.Ed.2d 779 (1986), overruled in part on other grounds, Casey, 505 U.S. 833, 112 S. Ct. 2791, 120 L.Ed.2d 674, and in Colautti, 439 U.S. at 400, 99 S. Ct. at 688. Because HB 382 requires women to remain pregnant even in the face of serious health concerns, it operates as a substantial obstacle to women seeking abortions. As such, it is unconstitutional.

C. Third-Party Consent

HB 382 also provides a civil action to the parents of a minor against a physician who performs a "partial-birth" abortion on the minor, unless the parents consented to the procedure or the pregnancy resulted from the parent's criminal conduct. The plaintiffs contend that this provision is unconstitutional under Casey because it requires a physician to obtain parental consent in almost all cases where a minor is pregnant and does not provide a confidential and expeditious judicial bypass procedure. The defendants respond that the statute does not attempt to evade constitutional requirements relating to consent bypass procedures. Instead, they argue that the consent requirement solely applies to the specific banned procedure, which if performed is a felony.

We reject the defendants' reading of the statute. The statute effectively requires a physician to obtain parental consent before performing almost every abortion procedure, except for hysterotomies and hysterectomies. In Casey, the Court reaffirmed that a State may require a minor seeking an

abortion to obtain the consent of a parent or guardian, "provided that there is an adequate judicial bypass procedure." 505 U.S. at 899, 112 S. Ct. at 2832. Because HB 382 does not provide a judicial bypass procedure, the consent provision is unconstitutional.

D. Irreparable Harm, Public Interest, Balance of Hardships

Plaintiffs have shown actual success on the merits of their claims. They have established that HB 382 is unconstitutionally vague and unduly burdensome on a woman's constitutional right to an abortion, and contains impermissible third-party consent requirements that violate the rights of minors seeking abortion services. In turn, this court has declared the statute invalid and unconstitutional. Because the statute infringes on the constitutional rights of women, plaintiffs have also shown that they and their patients would suffer irreparable harm if the court permitted the statute to go into effect. Likewise, the public interest is served by our determination that the statute is unconstitutional because, in so doing, we protect the constitutional rights of those who are affected by the statute. Finally, the balance of hardships in this case favors the plaintiffs. The protection of constitutional rights clearly outweighs any interest the State may have in promoting the interests of the fetus with a statute that is unconstitutional. Accordingly, we grant the plaintiffs' motion for a preliminary and permanent injunction.

VI. CONCLUSION

The Partial-Birth Abortion Ban Act is unconstitutionally vague in that it fails to give fair notice of the conduct that is prohibited. Moreover, HB 382 is unconstitutional because it has the purpose and effect of placing a substantial obstacle in

the path of a woman seeking an abortion before the fetus attains viability. It does so in two respects. First, HB 382 prohibits the safest and most common abortion procedures. As such, it places an undue burden on women seeking an abortion. Second, HB 382 makes no exception for circumstances in which the woman's health is at issue. The failure to provide an exception to the statute when the woman's health is compromised renders the statute unconstitutional. Finally, HB 382 creates third-party consent requirements, without providing a judicial bypass procedure. The failure to include a judicial bypass procedure in the statute renders that provision unconstitutional. Accordingly, the court grants the plaintiffs' motion for a preliminary and permanent injunction.

/s/ Charles P. Kocoras
Charles P. Kocoras
United States District Judge

Dated: February 12, 1998

In The

Supreme Court of the United States

No. 99A427

HOPE CLINIC, ET AL.,

Applicants,

v.

JAMES RYAN, ATTORNEY GENERAL OF ILLINOIS, ET AL.,

ORDER

UPON CONSIDERATION of the application of counsel for the applicants, the response and reply filed thereto,

IT IS ORDERED that the mandate of the United States Court of Appeals for the Seventh Circuit, case No. 98-1726, is hereby stayed pending the timely filing and disposition by this Court of a petition for a writ of certiorari. Should the petition be denied, this stay terminates automatically. In the event the petition is granted, this stay shall continue in effect pending the sending down of the judgment of this Court.

/s/ John Paul Stevens

Associate Justice of the Supreme Court of the United States

Dated this 30th day of November, 1999

No. 99-xxxx

IN THE

Supreme Court of the United States

OCTOBER TERM, 1999

Hope Clinic, et al.,

Petitioner,

v.

James Ryan, et al.,

Respondents.

EMERGENCY APPLICATION FOR STAY OR RECALL OF THE MANDATE OF THE 7TH CIRCUIT COURT OF APPEALS

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No. 99-xxxx

In The

Supreme Court of the United States

OCTOBER TERM, 1999

THE HOPE CLINIC, et al.,	)
	)
Petitioner,	)
	)
v.	)
	)
JAMES RYAN, et al.	)
	)
Respondents.	)

EMERGENCY APPLICATION FOR STAY OR RECALL OF THE MANDATE OF THE 7TH CIRCUIT COURT OF APPEALS

INTRODUCTION

In this case, which involves "matters of life and death, as they relate to a woman's exercise of a constitutional right [to abortion that] the Supreme Court has repeatedly recognized," Hope Clinic v. Ryan, No. 98-1726, Order of November 17 (Wood, J. dissenting) (citations omitted)[2], the

[2] Hope Clinic v. Ryan, No. 98-1726 (7th Cir. Nov. 17, 1999) (order denying stay of mandate) is attached hereto as Exhibit B. In addition, the following exhibits are attached hereto as follows: Hope Clinic v. Ryan, No. 98-1726 (7th Cir. Oct. 26, 1999), attached hereto as Exhibit A; Hope Clinic v. Ryan

United States Court of Appeals for the Seventh Circuit today has directed that the mandate of their judgment and Order of October 26[3], upholding the constitutionality and allowing the enforcement of Illinois' Partial Birth Abortion Ban Act ("the Act"), 720 ILCS 513/1-513/99, shall issue immediately – just one day following the Seventh Circuit's denial en banc, on a five to four vote, of plaintiffs' Motion for a Stay of Mandate Pending the Filing of a Petition for a Writ of Certiorari, filed November 9, 1999. Just this morning plaintiffs received the order denying their stay motion and oral notice that this afternoon, another order will issue directing the immediate issuance of the mandate. Once the mandate issues, plaintiffs, who are eminent physicians affiliated with medical school faculty and hospital of Northwestern University in Chicago, Illinois, and who treat high-risk obstetrical patients, will be prohibited from offering essential medical services to many of their pregnant patients, at great risk to their patients' health and possibly their lives. Therefore, pursuant to S. Ct. R. 23, plaintiffs hereby move a single Justice of this Court, Justice Stevens, Circuit Justice for the Seventh Circuit, for a stay of

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(Order issuing mandate), attached hereto as Exhibit C (to be faxed to the Court as soon as received by plaintiffs); Affidavit of Marilyn Connors Frederiksen, attached hereto as Exhibit D; Curriculum Vitae of Marilyn Connors Frederiksen, attached hereto as Exhibit E; Declaration of Marilyn Connors Frederiksen, attached hereto as Exhibit F; ACOG statement of Policy, attached hereto as Exhibit G; Affidavit of Cassing Hammond, attached hereto as Exhibit H; Curriculum Vitae of Cassing Hammond, attached hereto as Exhibit I; and Declaration of Cassing Hammond, attached hereto as Exhibit J.

[3] Hope Clinic v. Ryan, No. 98-1726 (7th Cir. Oct. 26, 1999) (hereafter "Slip Op. at __.")

the Seventh Circuit's mandate, pending the filing and disposition of plaintiffs' petition for a writ of certiorari to this Court. In addition, since the Seventh Circuit has directed that the mandate issue immediately, rather than in seven days, as normally contemplated by Fed. R. App. P. 41(b), plaintiffs hereby move this Court for an interim stay, or order the Seventh Circuit to recall, the issuance of the mandate immediately, pending the resolution of the remainder of this motion for a stay pending the filing and disposition of the writ.

As set forth further below, plaintiffs can satisfy the requirements for a stay of the mandate. "The relief sought is not available from any other court or judge," S. Ct. R. 23, as the Seventh Circuit, sitting en banc, has already denied plaintiffs' motion for a stay. In addition, as set forth further below, plaintiffs can establish: (1) a "reasonable probability" that four Justices of this Court will consider the issue sufficiently meritorious to grant certiorari or to note probable jurisdiction; (2) a "fair prospect that a majority of the Court will concludes the decision below was erroneous"; (3) "irreparable harm is likely to result from the denial of a stay," and (4) the "balance of equities" favors plaintiffs. Rostker v. Goldberg, 448 U.S. 1306, 1308 (1980) (Brennan, J.).

This case presents unique and compelling circumstances cautioning against deference to the Court of Appeals' decision on the stay motion. O'Connor v. Board of Ed. of Sch. Dist. 23, 449 U.S. 1301, 1304 (1980) (Stevens, J.). In denying the stay, the Seventh Circuit was deeply divided; while five justices voted to deny the stay (the same five that joined the majority opinion upholding the Act), four justices vigorously dissented (the same four that vigorously dissented in the underlying judgment.) Moreover, the Seventh Circuit's decision upholding Illinois' partial-birth abortion ban is in conflict with decisions from the Eighth Circuit on the same issue and with the Sixth Circuit on a similar abortion ban. Thus, the Seventh Circuit's denial of

plaintiffs' stay motion "display[s] a regrettable disregard for the importance of the issues implicated in these two cases, [and] the split in views about their proper disposition not only within [the Seventh Circuit Court of Appeals] but around the country . . .". Hope Clinic v. Ryan, No. 98-1726 (7th Cir. Nov. 17, 1999) (order denying Motion for Stay of Mandate) (Wood, J. dissenting). A stay is particularly appropriate where, as here, the view of a slim majority of the Seventh Circuit is contrary to the views expressed by other courts around the country, plaintiffs-physicians are at-risk of criminal prosecution and imprisonment, and the risk of irreparable harm to plaintiffs and their women patients, who "may find their health permanently impaired," once the mandate issues, is "considerable." Id.

I. A "REASONABLE PROBABILITY" EXISTS THAT FOUR JUSTICES OF THE SUPREME COURT WILL CONSIDER THIS CASE SUFFICIENTLY MERITORIOUS TO GRANT A WRIT OF CERTIORARI.

Certiorari is likely to be granted in this case consistent with the standards set forth in Supreme Court Rule 10. Not only did the majority of the court of appeals decide "an important federal question in a way that conflicts with relevant decisions" of the Supreme Court, S. Ct. R. 10(c), but this decision also is "in conflict with the decision of another United States court of appeals on the same important matter," S. Ct. R. 10(a).

A. The court of appeals' decision raises numerous questions meriting a writ of certiorari.

In their petition, plaintiffs will seek plenary review of the decision of the court of appeals on several grounds, including the following:

1. The decision misapplies the constitutional standards articulated in Planned Parenthood of S.E. Pennsylvania v. Casey, 505 U.S. 833 (1992), because the purpose and effect of the Illinois Act is to impose undue and unconstitutional burdens on a woman seeking to exercise her right to choose to have an abortion, because:

   a. the Act was meant to and will prohibit safe methods of abortion prior to viability; and,

   b. the criminal penalties and civil liability provisions of the Act were meant to and will chill physicians, who include abortion services as part of the medically necessary care they give patients, from providing constitutionally protected services.

2. The decision is in conflict with Supreme Court case law, starting with Roe and continuing unabated through Casey because:

a. the Illinois Act, which the majority upholds, makes no exception to the ban when the woman's health is threatened; and,

b. the Illinois Act provides such a narrow exception when the woman's life is threatened by the pregnancy to be constitutionally meaningless.

3. The majority erred in not holding the law unconstitutionally vague, because when a state criminal statute is so ambiguously worded "there is no meaningful difference between the forbidden and the privileged practice," Slip Op. at 38 (Posner, J., dissenting), such that the law likely will prohibit or chill constitutionally protected abortions, the statute is enjoinable in advance of any prosecution as unconstitutionally vague. Colautti v. Franklin, 439 U.S. 379, 390 (1979).

4. By directing the district court to enter a "precautionary injunction" while simultaneously vacating a declaratory judgment that the law was unconstitutional, the majority erred by:

a. abdicating its duty to enjoin enforcement of a non-severable criminal statute while

acknowledging it could not be enforced, as written by the Illinois legislature, in a manner consistent with the Constitution;

b. exceeding its power under Article III by directing issuance of an injunction although it purported to have found no violation of federal law;

c. violating Fed. R. Civ. P. Rule 65(d), which requires that injunctions be "specific in terms" and "describe in reasonable detail the act or acts sought to be restrained"; and,

d. violating principles of federalism and comity by creating hopeless ambiguity concerning whether the true meaning of the Illinois Act is to be worked out in prosecutions and civil suits in the state courts or instead through contempt proceedings in the federal court.

5. The majority contravened Supreme Court authority and the explicit provisions of Fed. R. Civ. P. 52, in wholly disregarding the factual findings of the district court in Illinois and by erroneously concluding that the

district court did not, indeed could not, make factual findings on the basis of affidavits rather than live testimony.

B. The Court is likely to review this case, which presents important questions of federal law that were decided in conflict with Supreme Court decisions and decisions of other courts of appeals.

A "reasonable probability" exists that four justices of the Supreme Court will vote to grant a writ of certiorari, consistent with the factors identified in Supreme Court Rule 10. First, the case involves critically important issues of women's health and the constitutional right to choose to have an abortion. Personal decisions relating to procreation, including abortion, are "central to the liberty protected by the Fourteenth Amendment." Casey, 505 U.S. at 851. For this reason the Court has reviewed – at least thirty times in the past two decades – the constitutionality of laws that threaten a woman's exercise of this fundamental right, particularly when, as is the case here, the Court of Appeals' decision conflicts with relevant Supreme Court abortion decisions, as set forth below.

Second, the decision of the Seventh Circuit's majority directly conflicts with those of two other federal circuits. The U.S. Court of Appeals for the Eighth Circuit recently affirmed injunctions preventing the enforcement of three state bans nearly identical to the laws at issue in this case. See, e.g., Carhart v. Stenberg, Nos. 98-324NE, 98-3300NE WL 753919 (8th Cir. Sept. 24, 1999), petition for cert. filed (Nov. 17, 1999); Little Rock Family Planning Services, P.A. v. Jegley, No. 99-1004EA, 1999 WL 753928 (8th Cir. Sept. 24, 1999) (Arkansas); Planned Parenthood of Iowa , Inc. v. Miller, No. 99-1372SI, 1999 WL 753770 (8th

Cir. Sept. 24, 1999) (Iowa). The Seventh Circuit's decision conflicts as well with the Sixth Circuit decision affirming the injunction against Ohio's ban on certain abortion procedures. Women's Med. Prof'l. Corp. v. Voinovich, 130 F.3d 187 (6th Cir. 1997), cert. denied, 118 S. Ct. 1347 (1998) (Ohio). Indeed, since 1995, thirty state "partial-birth abortion ban" laws have been enacted, twenty have been challenged and nineteen have been enjoined or limited by the trial courts that considered their constitutionality. Prior to the Seventh Circuit's decision and that of Judge Shabazz, only a single panel of the Fourth Circuit deviated from these consistent rulings that partial birth abortion bans were unduly burdensome of the abortion right, unconstitutionally vague, or both, by granting a stay of the district court's decision permanently enjoining the Virginia partial birth abortion ban. See Richmond Med. Ctr. for Women v. Gilmore, 183 F.3d 303 (4th Cir. 1999). The Supreme Court has not hesitated to grant certiorari in the face of a circuit split on cases involving abortion rights. See Rust v. Sullivan, 500 U.S. 173, 178 (1991) (certiorari granted "to resolve a split among the Courts of Appeals"). See also Braxton v. United States, 500 U.S. 344, 347 (1991) ('[a] principal purpose for which we use our certiorari jurisdiction . . . is to resolve conflicts among the United States courts of appeals").

Third, as detailed below, the majority misapplied Supreme Court law defining the contours of a woman's right to choose to have an abortion, see e.g., Casey, 505 U.S. at 846, and recent Supreme Court law on vagueness, see, Chicago v. Morales, ___ U.S. ___, 119 S. Ct. 1849 (1999). Fourth, the majority also substantially departed from the accepted course of judicial proceedings in numerous ways, including by directing the entry of a "precautionary injunction" without an underlying finding of unconstitutionality. See, e.g., New York City Transit Auth. v. Beazer, 440 U.S. 568, 570-71 (1979) (certiorari granted, in

part, on the grounds that the Second Circuit had departed from the usual and accepted course of judicial proceedings).

II. THERE IS A FAIR PROSPECT THAT THE SUPREME COURT WILL CONCLUDE THAT THE MAJORITY'S DECISION WAS ERRONEOUS.

A. The Court is likely to conclude that the Illinois Act is unconstitutionally burdensome of the abortion right because it bans safe methods of abortion.

In Casey, 505 U.S. at 846, this Court reaffirmed the essential holding of Roe v. Wade, 410 U.S. 113 (1973), that the Constitution protects a woman's right to choose to terminate her pregnancy prior to viability, and thereafter, if necessary to preserve her health or life. Thus, the Court long has held unconstitutional laws that prohibit safe methods of abortion prior to viability. See, e.g., Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 75-79 (1976) (a state law that banned use of a safe and commonly available method of second-trimester abortion – saline inductions – was unconstitutional). Casey affirmed this essential understanding of Roe. Casey, 505 U.S. at 846.

Both the Eighth Circuit and the Sixth Circuit, as well as numerous federal and state trial courts, have concluded that abortion bans similar, and in some cases identical to, the Illinois ban are constitutionally infirm because they prohibit safe and commonly available methods of abortion prior to viability. See, e.g., Little Rock Family Planning Services, 1999 WL 753928 at *2; Miller, 1999 WL 753770 at *2; Carhart, 1999 WL 753919 at *7; Voinovich, 130 F.3d at 209. The weight of the authority on the illegitimacy of "partial-birth abortion" bans, coupled with the uncontraverted factual submissions in the district court here,

leave no doubt that the reach of the contested Illinois law is potentially expansive enough to ban the most common and safest abortion procedures prior to viability, including many common variations of the D&E, as well as many inductions and suction aspirations. See Frederiksen Affidavit in Support of a Stay at ¶ 12 (hereafter Frederiksen Aff. at ¶); Frederiksen Declaration of December, 1997 at ¶ 48 (hereafter Frederiksen Dec. at ¶). This conclusion is buttressed by the majority's own holding that a precautionary injunction is necessary to prevent the impermissible application of the Illinois law to "a normal D&E or induction." Slip Op. at 17. By upholding the Illinois law, the majority put itself in conflict with decades of Supreme Court jurisprudence and risks reversal outright.

Moreover, even if the Illinois ban could be construed to prohibit only D&X abortions as defined by the American College of Obstetrics and Gynecology ("ACOG") and some "immaterial variations," Slip. Op. at 11, a construction plaintiffs respectfully continue to dispute, the Court's decision is likely to be reversed by the Supreme Court. The Constitution simply does not tolerate bans on safe abortions. Danforth, 428 U.S. at 79. Intact abortion procedures, of which the ACOG D&X is but one variation, are safe and available procedures utilized by physicians in current abortion practice, as indicated both in the affidavits of Dr. Hammond and Dr. Frederiksen filed in support of the stay and their earlier declarations. See Frederiksen Aff. at ¶ 9; Frederiksen Dec. At ¶ 41; Hammond Aff. at ¶ 3; Hammond Dec. at ¶ 16. Thus, any ban on such procedures constitutes an undue burden.

B. The Court is likely to conclude that the act's failure to include a health exception or an adequate life exception renders it unconstitutional.

The Illinois law also is flawed because it permits no exception to the ban – whatever it means – even when necessary to preserve a woman's health. The Supreme Court consistently has required abortion laws to contain health exceptions that permit the physician to exercise medical judgment and decide on a case-by-case basis which abortion procedure is safer for the woman. As the dissent correctly concluded:

> Even a law that limits only the right to abort viable fetuses – a limitation not found in the statutes challenged in this case – must, to pass constitutional muster, make an exception "for pregnancies which endanger the woman's life or health."

Id. (emphasis original to dissent) (citing Casey, 505 U.S. at 846). See also Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 769 (1986), overruled on other grounds, Casey, 505 U.S. 833 (1992). In holding that no such exception was needed, the majority disregarded this line of controlling Supreme Court precedent.

The Act's life exception is also constitutionally deficient and so cramped as to be meaningless. First, it is drafted in a manner that makes it ineffective in virtually all cases. Even when a woman's life *is* threatened, her physician still is prohibited from using the banned abortion methods unless no other method of abortion could be used to save her life, even if the alternative methods present far greater risks to the woman's health and future fertility. See, e.g., Hammond Dec. at ¶ 3(a), and Section III, below. Second, the limited exception does not allow for application of the exception when the woman's life is threatened by a mental, as opposed to a physical, disorder.

The Illinois ban is written so broadly and imprecisely as to potentially ban an indefinite array of safe and common abortion procedures, including the Dilation and Evacuation ("D&E") and even some vacuum aspirations (Frederiksen Dec. at ¶¶ 48, 50). The absence of a health exception and the inadequacy of a life exception leaves women at great risk. For some patients at some stages of pregnancy, alternative procedures may be either unavailable or unacceptably risky. When a physician performs an abortion for a woman whose health or life is at risk a physician needs maximum discretion to choose the procedure safest for her. See Frederiksen Dec. at ¶ 43.

The majority decision also ignores the uncontested factual findings by the district court describing the health and safety advantages of intact procedures. Hope Clinic v. Ryan, 995 F. Supp. 847, 857-61 (N.D. Ill. 1998). Because of these advantages, physicians typically strive to do as intact a procedure as possible, Frederiksen Dec. at ¶ 37, although the circumstances permitting the performance of an "ACOG D&X" may not often present themselves. These findings are in accord with the consensus of the American College of Obstetricians & Gynecologists, that "[a]n intact D&X . . . may be the most appropriate procedure in a particular circumstance to save the life or preserve the health of the woman, and only the doctor, in consultation with the patient, can make this decision." ACOG Statement at 2, attached to Frederiksen Affidavit. Dr. Hammond's affidavit in support of a stay provides further verification of the finding that the D&X procedure, under the medical circumstances he recently encountered, is sometimes the best procedure to preserve the woman's health. See Hammond Affidavit at ¶ 3 and Section III below.

C. The Court is likely to reverse the conclusion that the Act is not vague, especially given the chilling effect,

unmitigated by the "precautionary injunction," that the Act works on physicians who perform abortions.

Equally vulnerable to reversal is the majority's decision that the Illinois Act "does not violate federal law or create a significant danger of such violation," (Slip Op. at 32-33) (Posner, J., dissenting), i.e., that it is not unconstitutionally vague but nonetheless warrants a "precautionary injunction." In reaching this conclusion, the majority fundamentally misreads the Supreme Court's vagueness decisions. It first disregards the heightened vagueness scrutiny that the Supreme Court insists upon when an ambiguous statute threatens to inhibit the exercise of constitutionally protected rights. See Colautti, 439 U.S. at 391. It also erroneously suggests that any federal claim that a state law is unconstitutionally vague is premature until the statute is construed by state courts. See Slip Op. at 9. No case holds this, and the weight of Supreme Court authority is to the contrary, particularly when the ambiguous state enactment threatens fundamental rights. See, e.g., Babbitt v. United Farm Workers Nat. Union, 442 U.S. 289, 298 (1979); Danforth, 428 U.S. at 62; Doe v. Bolton, 410 U.S. 176, 188 (1973).

The majority then undercuts its own holding that the Illinois Act is not vague and thus does not violate federal law by offering its advice on how the Act might be read to preserve its constitutionality, Slip Op. at 10-15,[4] and

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[4] The Illinois Act is not "reasonably susceptible" to any of the "saving" constructions the majority hypothesized and which are themselves illegitimate exercises of judicial power. Reading the Illinois Act to "assimilate the medical definition of D&X . . . ," Slip Op. at 10, is not in accord with Illinois Supreme Court decisions refusing to restrict or enlarge the meaning of a statute. See Henrich v. Libertyville High

by further opining that a "precautionary injunction" is needed, nonetheless, to prevent the enforcement of the Act against constitutionally permissible abortions such as "normal D&Es and inductions." If the majority means what it says – that the Illinois Act, as written, does not violate the federal Constitution – then the precautionary injunction it authorizes not only would be unnecessary but also illegitimate, because a judicial order can be issued only on the basis of a legal violation. See Swann v. Charlotte-Mecklenburg Bd. of Educ., 402 U.S. 1, 16 (1971). Moreover, far from respecting the independent power of the state judiciary as it claims to do, the majority in fact challenged that power, without apparent legal basis, by creating hopeless confusion about whether the "true meaning" of the Illinois Act will be resolved by the state courts in common law fashion or by the federal court in contempt proceedings. Thus, the majority would "expand[] federal judicial power over the states by a method that the Supreme Court has never countenanced and that violates Article III of the Constitution." Slip Op. at 31 (Posner, J., dissenting).

The majority does not describe specifically what it considers a "normal D&E or induction" (Slip Op. at 18) or what "immaterial variation" to the ACOG D&X

School, 186 Ill. 2d 381, 712 N.E. 2d 298, 305 (1998). Similarly it is unlikely that Illinois courts will upset decades of case law construing the "knowing" scienter element to mean knowledge that one's "acts create a strong probability" of causing the prohibited result, see People v. Daniels, 301 Ill. App. 3d 87, 95, 702 N.E.2d 324, 330-31 (1st Dist. 1998), and instead construe the explicit "knowing" term in the Partial-Birth Abortion Ban Act, alone, to mean "willful," as the majority would prefer.

permissibly might be banned.[5] As the dissent notes correctly, "it is extremely difficult, indeed probably impossible, to distinguish a 'partial birth abortion' from the methods of abortion that are conceded to be privileged." Slip Op. at 38 (Posner, J., dissenting). See also Frederiksen Aff. at ¶¶ 9-11 (there are no clear distinctions in medical practice between the various abortion procedures, and that in performing a D&E, extracting the fetus as intact as possible is usually the safest course for the woman).

Thus, any protection the precautionary injunction is thought to afford is illusory. Moreover, requiring physicians to risk criminal prosecution to ascertain the meaning of this Act is completely at odds with Supreme Court jurisprudence, including most recently the Morales case, where the Court observed that "[t]he Constitution does not permit a legislature to 'set a net large enough to catch all possible offenders, and leave it to the courts to step inside and say who could be rightfully detained, and who should be set at large.'" 119 S. Ct. at 1861. See also Bolton, 410 U.S. at 188; Baggett v. Bullet

In summary, without a stay, the risk of criminal prosecution and conviction by state courts who, in common law fashion are "working out . . . the outer boundaries" of the true meaning of the Illinois Act, will likely lead Dr. Frederiksen, Dr. Hammond, and other Illinois physicians to stop providing their patients not only with the ACOG D&X but also anything that might constitute an undefined "immaterial variation" of that procedure, including many procedures frequently performed now and considered part of a "normal D&E or induction."

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[5] The specificity provisions of Rule 65(d) are "not mere technical requirements," but instead were "designed to prevent uncertainty and confusion on the part of those faced with injunctive orders." Schmidt v. Lessard, 414 U.S. 473, 476 (1974), vacated on other grounds, 421 U.S. 957 (1975).

D. Other aspects of the majority decision are vulnerable upon review.

The majority also takes liberties with Rule 52 in its cavalier dismissal of the extensive factual findings made by the Illinois district court. Rule 52 allows district courts to make findings of fact on "physical or documentary" evidence. Fed. R. Civ. P. 52(a); Anderson v. Bessemer City North Carolina, 470 U.S. 564, 574 (1985); Eirhart v. Libbey-Owens Ford Co., 996 F.2d 837, 840 (7th Cir. 1993) ("Rule 52 allows for matters to be tried to the district court on a written record; we do not read the Rule to require that an evidentiary hearing be held"). See also Ginsu Prods., Inc. v. Dart Indus., Inc., 786 F.2d 260, 263-65 (7th Cir. 1986); Lawson Prods., Inc. v. Avnet, Inc., 782 F.2d 1429, 1439 (7th Cir. 1986). Notably, the facts in this case were not even contested; defendants submitted no evidence, documentary or otherwise, to contradict plaintiffs' assertions, despite repeated invitations by the district court to do so. See Hope Clinic, 995 F. Supp at 850-51. "Findings do not lose weight by being based on uncontested facts." Slip Op. at 45 (Posner, J., dissenting).

III. PLAINTIFF PHYSICIANS AND THEIR PATIENTS WILL SUFFER IRREPARABLE HARM IF THIS COURT'S MANDATE IS ENTERED; THE BALANCE OF THE EQUITIES SUPPORT THE ISSUANCE OF A STAY.

The purpose and effect of the Illinois Act, notwithstanding the "precautionary injunction" and the range of ostensibly constitutional constructions suggested by the majority, will continue to deter physicians from performing constitutionally protected abortions. The imprecision and the

potential breadth of the Illinois ban put physicians at risks for performing the safest and most commonly available methods of abortion, including the D&Es and some suction aspirations. See Hope Clinic, 995 F. Supp. at 854-55. Given the very real risks of criminal prosecution and civil liability, Illinois physicians brave enough to continue providing abortions will be forced, in effect, either to take extra steps to ensure fetal demise at the outset of the procedure or, more frequently, to extract the fetus in segments, often contrary to the accepted standard of medical care and contrary to their best medical judgment.[6] As a direct and immediate

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[6] The majority is wrong when it stated that "none of the plaintiffs-physicians or clinics in Illinois uses the D&X, and none asserts any desire to start." Slip. Op. at 23. In their original declarations, plaintiffs Dr. Frederiksen and Dr. Hammond explained that they had performed abortions in which intact fetuses were partially delivered before their demise. Frederiksen Dec. at ¶ 3 (describing her performance of abortions resulting in a largely intact fetus); Hammond Dec. at ¶¶27-33 (describing an abortion containing all the elements of an ACOG D&X except conversion to a footling breech). These procedures may fall within what the majority considers "variations" of the D&X procedure or not "normal D&Es." The majority also is wrong when it states that no Illinois doctor has evinced a "desire to start" performing D&X procedures. Slip. Op. at 23. After acknowledging familiarity with the D&X procedure, Dr. Frederiksen swore in her 1997 declaration that "it is likewise essential that in providing care I have discretion to consider the full panoply of safe methods of abortion and to proceed with the method most appropriate for each patient." Frederiksen Dec. at ¶ 18. As the attached affidavit of Dr. Frederiksen attests, she has exercised the discretion to consider all of the "safe methods of abortion," and when it is "most appropriate" for her patient, she now attempts to use the ACOG D&X procedure.

consequence of this court's decision, their patients, some of whom are dangerously ill, will face heightened and wholly unnecessary risks. These risks include the increased risk of having the uterus perforated by virtue of the additional injections of sharp surgical instruments into the uterus so as to extract the fetus in segments rather than intact, the risk that those bony segments will lacerate the cervix as they are extracted, and the increased risk of infection and complications of anesthesia. Frederiksen Aff. at ¶ 9; Hammond Aff. at ¶ 3.

Any of these increased risks can cause the woman to suffer serious bodily harm. For example, one of Dr. Hammond's recent patients who terminated a pregnancy was extremely ill with leukemia. As a consequence of her disease, her blood had a very low platelet count and the blood's ability to clot was extremely compromised. Dr. Hammond was able to "partially vaginally deliver" the fetus intact to the level of the head, which was then compressed, thereby "killing the fetus and completing the delivery." Hammond Aff. at ¶ 3(a). Had Dr. Hammond been chilled or prohibited from attempting an intact procedure and tried instead to extract the fetus in segments, and had the patient suffered cervical laceration or uterine perforation as a result, then the attendant blood loss could well have led to serious health problems or even her death, given her poor clotting function. Still, Dr. Hammond could not say that "no other procedure would suffice" to save this patient's life, the showing required to evoke the single exception to the Illinois ban, because the more serious risk of perforation, though real, was small, and the patient might well have survived these complications. Nonetheless, Dr. Hammond had no doubt

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Frederiksen Aff. at ¶ 5. Dr. Hammond adopts these statements as representative of his own practice. Hammond Aff. at ¶ 2.

that the intact procedure was the safest for the patient and significantly reduced the relevant risks of alternative procedures. Id. at ¶ 3(a).

Should the mandate issue, women who seek to terminate otherwise wanted pregnancies because the fetus is afflicted with serious anomalies also would suffer. In some such cases, an intact fetus will provide physicians performing the genetic analysis with additional essential information needed to conclusively determine what caused the anomaly to occur. Frederiksen Aff. at ¶ 9. To deprive these women of the opportunity to gain the most accurate information about the fetal anomaly, by which a physician can more precisely assess whether a future pregnancy would be so afflicted, is senseless, see id. at ¶ 9, and imposes a serious infringement on their constitutional right to procreate. See Lifchez v. Hartigan, 735 F. Supp. 1361 (N.D. Ill. 1990) (Constitution protects right to have access to medical technology for genetic testing).

Restrictions on abortion procedures create irreparable harm not merely because they impose upon constitutional rights, but also because they create harm to health and life that cannot be rectified by legal remedies. Missed opportunities for health care procedures cannot be compensated properly and thus constitute irreparable harm. Henderson v. Bodine Aluminum Inc., 70 F.3d 961 (8th Cir. 1995). Monetary harm will not adequately compensate a women whose health or future fertility have been lost by statutes that require women to undergo less appropriate and riskier abortion procedures. See Doe v. Charleston Area Med. Ctr., 529 F.2d 638, 644 (5th Cir. 1981) (holding that "denial under court of law of the right to abort, implicit in the right to be let alone, constitutes irreparable injury").

When evaluating claims of irreparable injury, a court should examine competing equities. Here, the risks to the health of women are extensive, as set forth above. As the dissent recognized, in the face of these risks, some women

may feel compelled to forego an abortion altogether, seriously compromising their health (as many women who seek abortions at this stage of pregnancy do so for health-related reasons). Slip. Op. at 40, 42 (Posner, J. dissenting).

No competing equaties tip the balance in favor of denying the stay. As four judges of the Seventh Circuit observed, the Act does not "protect the lives of fetuses either directly or by persuading a woman to reconsider her decision to seek an abortion;" it also does not "seek to protect the lives or health of pregnant women, or anybody else;" nor does it "outlaw a particularly cruel or painful or horrifying mode of abortion." Id. at 35-37. Thus while the potential injury to women is severe, and includes increased risk of both death and serious bodily harm, the State is injured merely in its inability to use a legislative enactment that compromises women's health to "dramatize the ugliness of abortion." Id. at 38 (citing Planned Parenthood of Wisconsin v. Doyle, 162 F.3d 463 (7th Cir. 1998)).

WHEREFORE, for reasons set forth herein, plaintiffs-physicians in the Hope Clinic case ask that an order be entered staying or recalling the mandate that will otherwise issue today from the Seventh Circuit's judgment of October 26, 1999, and continuing the stay until such time as this Court rules on plaintiffs' forthcoming Petition for Writ of Certiorari.

Respectfully submitted,

By:

/s/ Colleen K. Connell
One of the Plaintiffs' Attorneys

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EXHIBIT D

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

THE HOPE CLINIC, MARILYNN CONNERS FREDERIKSEN, M.D., NORMAN A. GINSBERG, M.D., CASSING HAMMOND, M.D., LAUREN STREICHER, M.D., DAVID ZBARAZ, M.D., et al.,	)	Appeal from the United States District Court for the Northern District of Illinois, Eastern Division
Plaintiffs-Appellees,	)	
v.	)	
	)	No: 97 C 8702
JAMES RYAN, Attorney General of the State of Illinois, in his official capacity; RICHARD DEVINE, State Attorney for Cook County, in his official capacity,	)	Hon. Charles P. Kocoras
Defendants-Appellants.	)	

AFFIDAVIT OF
MARILYNN CONNERS FREDERIKSEN

1. As a plaintiff in this lawsuit, I submit this Affidavit in support of Plaintiffs-Appellees' Motion for Stay of the Mandate. My qualifications as set forth in my curriculum vitae, which is attached hereto as Exhibit A, and the bases for my opinions are essentially the same as those set forth in my original declaration in this case, filed on December 16, 1997, at ¶¶ 1-3, attached as Exhibit B.

2. Having read the decision this Court issued on October 26, 1999, and having discussed it at length with Colleen K. Connell, the attorney who represents me in this action, I submit this affidavit to express my continuing, and now heightened, concern about the harm that my patients and I will suffer if the Illinois Partial-Birth Abortion Ban Act ("the Act" or "the Illinois Act"), goes into effect, even as modified by the "precautionary injunction" ordered by this Court. I also write to clarify the contours of my current abortion practice, which has evolved in some significant ways since I submitted my original declaration. I hope by these descriptions to demonstrate to the Court why the stay is critical to me and to my patients.

3. I have practiced medicine for 25 years and have performed abortions for 23 of those years. I practice medicine as a faculty member and as a physician at Northwestern Memorial Hospital. This is a large urban teaching hospital and my patients include women whose pregnancies are considered "high risk" for a variety of reasons, including: medical conditions which pre-exist the pregnancy, such as leukemia, other forms of cancer, HIV-infection, and disorders of the woman's immune system, such as lupus; medical conditions such as diabetes, caused or exacerbated by the pregnancy; lack of access to early prenatal care, in most cases because of poverty, youth or both; multiple pregnancies (e.g., twins and triplets); and pregnancies complicated by fetal anomalies. Many of my patients are referrals from Chicago-area and down-state physicians or hospitals, including hospitals that do not offer second-trimester abortion services, as well as out-of-state physicians, including those in surrounding states, such as Indiana.

4. Every time I enter the procedure room to perform an abortion, I do so with the intent to perform the abortion procedure that is the best and the safest procedure for the woman who is my patient. In deciding which method

of abortion I will use to terminate a woman's pregnancy, I exercise my medical judgment and weigh many different factors, including the health of the individual patient and any medical problems she may suffer, the condition of the fetus, and the duration of the pregnancy. As I have gained experience performing abortions and as the practice of medicine has progressed, with the advent of new medications (such as RU 486) and the refinement of existing procedures, I have added new techniques and methods of abortion to the services I provide my patients. These refinements and development of additional techniques have continued throughout the pendency of this case.

5. As I stated in my original declaration at ¶ 4, I had, at the time this case was filed nearly two years ago, performed many abortions in which I deliberately delivered into the vagina an intact, living fetus, excepting the head, before compressing the fetal skull and completing the delivery. I continue to perform such intact abortions to this day. I also now, when appropriate, perform intact abortions in a manner that conforms to what I understand to be the "intact dilatation and extraction" technique as described by the American College of Obstetricians and Gynecologists (ACOG). See ACOG Statement of Policy, attached as Exhibit C. ACOG describes the procedure as involving, in the stated sequence, each of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;

2. instrumental conversion of the fetus to a footling breech;

3. breech extraction of the body excepting the head; and

4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

I call this procedure the "ACOG D&X." At the time I filed my first affidavit, I was not, as a technical matter, performing the ACOG D&X procedure, because I was not attempting an instrumental conversion of the fetus to a footling breech prior to any effort to remove the fetus intact. However, I now utilize this conversion technique in appropriate medical circumstances. I consider the addition of the conversion technique to be a refinement of my practice, because in certain patients it facilitates the delivery of an intact fetus and thus, in my opinion, a safer abortion.

6. The ACOG procedure requires "partial evacuation of the intracranial contents of the living fetus." I'm not sure whether ACOG, for this step, had a particular method in mind, but I know that there are a number of ways to achieve such "partial evacuation" and thus effect the safe removal of the head, including to collapse the head by suctioning the contents or by using forceps to compress it without the use of suction. I do only the latter. However, I understand both of these techniques to be prohibited, in conjunction with the other steps of an ACOG D&X, by the Court's decision.

7. As outlined in my earlier submission, there are of course many situations in which I can, and long have, accomplished intact deliveries without following all four steps described by ACOG.

a. For example, sometimes my patient presents with a spontaneously dilated cervix, often because of premature labor or rupture of the membranes. In that case, I generally do not need to cause additional "deliberate dilatation of the cervix" before I perform an intact procedure.

b. Instrumental conversion often is not necessary for an intact procedure. In the mid to late second trimester of pregnancy, the fetus presents feet-down – breech – nearly as often as it presents vertex (head-down); a breech presentation obviates the need for any conversion.

8. These variations may combine in any number of ways, all of which result in my delivery into the vagina of a living intact fetus, excepting the head, and then compressing the head "to effect vaginal delivery of a dead but otherwise intact fetus."

9. There are a number of reasons why, when possible, I attempt to remove the fetus intact, all of which I outlined in my earlier submission. The more intact the fetus when removed, the fewer times I must introduce instruments, many of which are sharp, into the uterus. The less instrumentation that is required in the uterus, the less risk there is of uterine perforation. Intact procedures are therefore especially important to patients whose uteruses are fragile (because of preexisting scars from, for example, multiple cesarean sections or prior uterine surgery to remove tumors) and who should neither endure the intense contractions of an abortion by the induction of labor nor risk perforation by repeated instrumentation. Also, when the fetus is removed in parts, the bony fragments can be sharp and pose a risk of laceration, particularly given the soft condition of the cervix and its surplus of engorged blood vessels. Accordingly, an intact procedure also offers the advantage of less residual blood loss. Finally, an intact fetus offers advantages for testing to ascertain the cause of fetal anomalies, an advantage important to my practice and always important to families struggling to assess the risks of conceiving another pregnancy afflicted by fetal anomalies and confronting again the decision of whether to have an abortion.

10. Faced with these or any number of other medical circumstances, I would want to attempt an intact

procedure of one variety or another. And faced with these conditions, I have attempted as recently as a month ago, and would want to continue to attempt an intact procedure by means of the ACOG D&X, where that procedure is medically appropriate. I cannot see any medical basis for distinguishing among the variations of intact procedures – nor can I see any reason for condemning surgical abortions that result in largely intact fetuses rather than dismembered fetuses. Intact procedures are safe, and indeed, as described above, often the safest procedure for my patients.

11. Moreover, there is simply no clear delineation in my abortion practice between intact and dismemberment procedures. When I set out to perform a surgical, second-trimester abortion, I generally proceed with the intent to remove the fetus as intact as possible, for all of the reasons referenced above and in my earlier submission. So, for example, whenever the fetus presents breech, the amount of dilation permitting, I attempt an intact removal. However, depending upon the age of the fetus, its fragility and other factors, I am not always able to deliver an intact fetus. In such circumstances, I alter my course as necessary and remove the fetus in segments. On other occasions, based on the level of cervical dilation and positioning of the fetus, I may begin to utilize a technique to dismember the fetus. On some of these occasions, however, I find, once I have reached into the uterus, that I can, in fact, remove the fetus intact, in which case I proceed to do so. I know this potential exists whenever I begin such a procedure. On other occasions, I have set out to instrumentally convert the fetus and remove it intact, only to find the conversion impossible. In that case, I must change course and remove the fetus in segments. In other words, the course of an abortion, like the course of any surgery, changes depending on the particular circumstances as they present. Yet I or any well trained physician will always proceed deliberately in response to circumstances as they develop, and I almost always have knowledge of the

range of consequences my actions will produce. Furthermore, in any surgical abortion after approximately 14 weeks of pregnancy, I fully expect that if I successfully deliver the intact fetal body, the head (the largest part) will lodge at the cervix, and I will have to compress it to complete the removal.

12. I have discussed the procedures above because of the Court's suggestion that the Act may be read to prohibit the ACOG D&X and some unspecified variations. However, I do not understand how the words "partially vaginally delivers a living human fetus or infant before killing the fetus or infant and completing the delivery" could be used to describe only the ACOG D&X and some variations. The Act makes no reference to an intact fetus, no reference to delivery up to the head, and no reference to compressing the skull to complete the delivery. Even after reading the Court's decision and talking with my attorney, I still do not understand how the words of the Illinois Act exclude from the statutory ban many of the safe, common abortion procedures I perform, particularly dilation and evacuation (D&E), which is the most common second-trimester abortion procedure in my practice, in Illinois, and in the nation.

13. The Court has said that the statute may not be applied to a "normal D&E or induction," terms the Court does not define. I do not know if my D&Es count as "normal." In short, I know every time I start a D&E that I will likely, in the words of the statute, "partially vaginally deliver" a living fetus, and then kill it before completing the delivery. In a D&E, after I dilate the cervix, I typically rupture the membranes. I then reach through the vagina, through the cervix, and into the uterus with forceps; grasp the fetus with the forceps; and deliver into the vagina the part I have grasped. This is how I empty ("evacuate") the uterus, and it often entails delivering part of the fetus while the fetus still has a heartbeat.

14. Indeed, even if the law were limited to "partially vaginally delivering" an intact living fetus, many of my D&Es would still run afoul of the law. That is because – while my forceps sometimes dismember a fetal part inside the uterus, before I deliver that part – it is more typical that I grasp part of the fetus in the uterus and deliver that part while it is still attached to the rest of the fetus. Hence, with my first pass with the forceps in a D&E, I typically deliver part of an intact, living fetus that is partially in the uterus and partially in the vagina. When the procedure goes on to entail dismemberment, which is often the case, the dismemberment occurs because of resistance at the internal cervical os. This resistance is caused by tension between the part I am pulling, which is outside the uterus (and in the vagina), and the rest of the fetus, which remains inside the uterus, too large to pass through the cervical os. I thus perform the dismemberment – and so kill the fetus – only after "partially vaginally delivering" the intact fetus.

15. I understand that the Court has directed that a precautionary injunction issue that will remain in effect until the State has provided additional specificity, determined possibly through the course of criminal prosecution or civil suits, in situations which, as the Court acknowledges, the parties may disagree about whether the abortion procedure in question is proscribed. I don't know how to practice medicine in such situations when the determination of which of my procedures and variations are legal and which are not could be determined in lawsuits and prosecutions against me.

16. The Court's decision creates serious legal and ethical dilemmas for me. If I continue to practice medicine in conformity with my best medical judgment and the prevailing consensus of medical opinion within my specialty of obstetrics and gynecology, I will continue to offer patients the ACOG D&X and other intact procedures when medically appropriate. Practicing in conformity with my best medical judgment thus would put me at risk of criminal prosecution,

imprisonment, and loss of my license to practice medicine, deprivations that are professionally and, as the mother of three children, personally painful to contemplate. The alternatives are painful as well. If I am unable to offer my patients intact procedures, I expose them to health risks that otherwise could be minimized or avoided altogether. What, for example, am I to do when I confront a patient who has spontaneously dilated, to the point where I could readily remove the fetus intact up to the head? Must I then, to avoid liability, remove the fetus in segments, despite the added time and risk that alteration will require? What if the deliberate dilation readily permits conversion and intact removal? Again, must I deliberately avoid proceeding in the manner I consider best? Similarly, if the law goes into effect and leads me to attempt to administer a toxic substance that kills the fetus prior to its evacuation from the uterus, the patient is exposed to unnecessary risks of infection and complications as well as additional expense. A ban on abortions of intact fetuses would also deprive a significant fraction of my patients of the opportunity for the most complete pathological examination of a fetus with lethal or other severe anomalies and the best opportunity to evaluate the risk of recurrence in future pregnancies.

17. In my view, a restriction on intact procedures will also curb medical advances in abortion practice. I and other practitioners increasingly have attempted intact procedures, including those that conform to the ACOG four-step definition because we consider such procedures to be an advance. The decision of the Court, if not stayed, will halt that progress, to the detriment of women and their families. Although I would like to think that I will obey the law in all instances, I am uncertain how I, or any physician who practices obstetrics and provides abortions, could practice medicine in conformity with their best medical judgment and strive for the best possible health outcome for their patients without violating the Illinois Partial Birth Abortion ban.

/s/ Marilynn C. Frederiksen
Marilynn Conners Frederiksen

Subscribed and sworn to before me
this 4 day of Nov. 1999.

/s/ Beth Grogan
Notary Public

EXHIBIT E

CURRICULUM VITAE

Marilynn Conners Frederiksen, M.D.
680 N. Lake Shore Drive., Suite 1000
Chicago, Illinois 60611
312-908-8486 Patient Number 908-7382
FAX 312-908-8711
e-mail mcf810@nwu.edu

BORN: September 12, 1949, Chicago, Illinois

MARRIED: James W. Frederiksen, M.D., July 10, 1971

FAMILY: John Karl Frederiksen, March 1, 1976
Paul Stanley Frederiksen, April 11, 1980
Britt Louise Frederiksen, August 28, 1984

EDUCATION: Cornell College, Mount Vernon, Iowa;
B.A. (Magna Cum Laude), May 1970

Boston University Medical School, Boston, MA:
M.D., May, 1974

POSTGRADUATE EDUCATION:

Intern in Pediatrics, University of Maryland Hospital, Baltimore, Maryland, 1974-1975

Resident in Pediatrics, University of Maryland Hospital, Baltimore, Maryland, 1975-1976

Resident in Obstetrics and Gynecology, Harvard University, Boston Hospital for Women, 1976-1979

Fellow, Maternal-Fetal Medicine, Northwestern University Medical School, Chicago, Illinois 1979-1981

NIH Fellowship in Clinical Pharmacology, Northwestern University Medical School, Chicago, Illinois 1981-1983

PRESENT POSITION:

Associate Professor of Obstetrics and Gynecology, Tenured 1991
Associate in Clinical Pharmacology, Northwestern University Medical School, Chicago, Illinois, 1991-Present

Section Head of General Obstetrics and Gynecology,
Medical Director Prentice Ambulatory Care,
Medical Director Prentice Ambulatory Surgery, 1993-

APPOINTMENTS:

Assistant Professor of Obstetrics and Gynecology, Associate in Clinical Pharmacology, Northwestern University Medical School, Chicago, Illinois, 1983-1991

Instructor in Obstetrics and Gynecology, Northwestern University Medical School, Chicago, Illinois, 1981-1983

LICENSURE:

Illinois, 1979

SOCIAL SECURITY NUMBER:

353-40-0398

BOARD CERTIFICATION:

National Board of Medical Examiners
Part I, II, and III (1975)

American Board of Obstetrics and Gynecology,
Diplomate, November, 1982

American Board of Obstetrics and Gynecology
Maternal-Fetal Medicine Subspecialist
Diplomate, 1983

American Board of Clinical Pharmacology
Diplomate, 1991

PROFESSIONAL ASSOCIATIONS:

Fellow of the American College of Obstetricians
and Gynecologists

Society of Perinatal Obstetricians

Central Association of Obstetricians and
Gynecologists
Nominating Committee, 1994
Board of Directors, 1996-

Chicago Gynecologic Society, Treasurer 1994-97

Northwestern Memorial Hospital Women's
Association, Executive Committee Elected
Member at Large, 1989-1991

American Society for Clinical Pharmacology and
Therapeutics, Chairman Section of Pediatric &

Perinatal Pharmacology 1993-1996; Member Board of Directors, 1993-96. Vice-President 1996-97.

American Board of Obstetrics and Gynecology Examiner 1997

HONORS:

Phi Beta Kappa, Cornell College, Mount Vernon, Iowa

AWARDS:

Medal of the American Chemical Society, Cornell College, 1970

Owen L. Coon Fellowship, 1983-1984.

Chicago Community Trust Faculty Development Award, Northwestern University Medical School, 1983-1984.

Pharmaceutical Manufacturers' Association Foundation Faculty Development Award, 1984-1986.

Civil Liberties Award of the Roger Baldwin Foundation of ACLU, 1991.

1997-98 ELAM Program for Women
Marlynn S. Singleton Scholarship for ELAM Program for Women, 1997

HOSPITAL APPOINTMENTS:

Adjunct Attending, Northwestern Memorial Hospital, Chicago, Illinois 1981-1983

Associate Attending, Northwestern Memorial Hospital, Chicago, Illinois 1983-1989

Attending, Northwestern Memorial Hospital, Chicago, Illinois 1989-Present

Faculty Physician in the Clinical Research Center, 1983-1984

COMMITTEE ASSIGNMENTS:

Northwestern Memorial Hospital, Pharmacy and Therapeutics Committee, 1981-. Subcommittee on antibiotic formulary, 1986-

Northwestern Memorial Hospital, Prentice Women's Hospital Research Committee, 1983-1994

Northwestern Memorial Hospital, Medical Records Committee, 1984-, Chair, 1988-

Northwestern Memorial Hospital, Department of Obstetrics and Gynecology Quality Assurance Committee, 1987-

Northwestern Memorial Hospital, Quality Management Committee, 1989-

Northwestern University Medical School GCRC Scientific Advisory Committee, 1990-

Northwestern University Medical School Admissions Interviewing Committee, 1991-1992

Northwestern University Medical School Admissions Committee, 1995-

Northwestern University Medical School, Ethics and Human Values, Oversight Committee, 1990-1994

Northwestern University, Institutional Review Board, 1992-

Northwestern University, Sexual Assault Hearing Board, Alternate Member, 1992-95, Regular Member 1995-

Northwestern University General Faculty Committee, elected 1994-97
Subcommittee on Women and Minorities, Chair 1996-97

Northwestern University Medical School Dean's Management Committee, 1997-

Northwestern University, Department of Obstetrics and Gynecology Committees: Prentice Operations, Appointments and Promotions, NMFF Practice Committee, 1993-. Operating Room Committee 1993-1994 Northwestern Healthcare Corporation Board of Directors, 1994-

Northwestern Medical Faculty Foundation Committees: Managed Care, Risk Management, Facilities Planning. Elected member at large Board of Directors, 1995-

NATIONAL COMMITTEES:

USP Obstetrics and Gynecology Advisory Panel 1985-1990, 1990-1995,1995-2000

Northwestern University Medical School Delegate to the USP Convention
1990, 1995. Convention 1995 Resolutions Committee 1994-1995.

Board of Directors Cornell College Alumnae Assoc., 1986-1990

NIH, General Clinical Research Central Committee, 1989-1993, Chair 1992-1993.

NHLBI Task Force on Asthma and Pregnancy, 1991-1992

NIH DRG SBIR Ad Hoc Study Section, 1993

NIH NCRR STRB Ad Hoc Study Section, 1995

NIH NCRR RCMI Special Review Committee, 1995

NIH NCRR Special Review Committee, Chair, 1996

NIH NCRR STRB Ad Hoc Study Section, 1997

NIH Reviewers Reserve 1993-1997.

National Board of Medical Examiners Step 3 Writing Task Force 1996-

MANUSCRIPT REVIEW:

American Journal of Obstetrics and Gynecology
Obstetrics and Gynecology
Journal of the American Medical Association
International Journal of Gynecology and Obstetrics
Clinical Pharmacology and Therapeutics
Journal of Pharmacology and Experimental Therapeutics
Fertility and Sterility
Contraception
Drug Metabolism and Disposition

EDITORIAL BOARD:

Dialogues in Contraception, 1992-1996
Clinical Pharmacology and Therapeutics, 1993-

GRANTS (Active):

Women's Health Initiative
Principal Investigator: Phillip Greenland
Collaborating physician: Marilynn C. Frederiksen
Percent effort: 5%

Upjohn Pharmacia Inc.
Principal Investigator: Marilynn C. Frederiksen
Comparison of Cyclo-Provera with Ortho-Novum 7/7/7
Directs: $86,000.

Upjohn Inc.
Principal Investigator: Marilynn C. Frederiksen
Unrestricted grant $30,000.
Grant in support of Catherine Stika Clinical Pharmacology Fellowship
$30,000

EXHIBIT F

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

THE HOPE CLINIC, MARILYNN CONNERS FREDERIKSEN, M.D., NORMAN A. GINSBERG, M.D., CASSING HAMMOND, M.D., LAUREN STREICHER, M.D., DAVID ZBARAZ, M.D., et al.,	)	
Plaintiffs-Appellees,	)	CIVIL ACTION NO: 97 C 8702
v.	)	
JAMES RYAN, Attorney General of the State of Illinois, in his official capacity; RICHARD DEVINE, State Attorney for Cook County, in his official capacity,	)	
Defendants-Appellants.	)	

DECLARATION OF MARILYNN CONNERS FREDERIKSEN, M.D.

MARILYNN CONNERS FRDERIKSEN, M.D., declares and states the following:

1. I am a physician licensed to practice in the State of Illinois. I received an M.D. degree in 1974 from Boston

University Medical School. I am actively engaged in the practice of obstetrics and gynecology in Chicago. I am currently the Section Head of General Obstetrics and Gynecology, an Associate Professor Obstetrics and Gynecology and an Associate Professor in Clinical Pharmacology at Northwestern University Medical School in Chicago. In that capacity, I supervise approximately 15 physicians and residents, as well as examine and treat patients. I am a fellow of the American College of Obstetricians and Gynecologists. I am a Diplomate of the American Board of Obstetrics and Gynecology and have been certified by that Board as a Maternal-Fetal Medicine subspecialist. I provide my patients with an array of services, including prenatal care, fetal diagnoses, labor and delivery, and fetal therapy. I also perform abortions for patients between six and twenty-four weeks measured from the first day of the woman's last menstrual period ("LMP"). Many of my abortion patients have pregnancies complicated by severe or fatal fetal anomalies; others are in need of abortion services to protect their health or lives; some are pregnant as a result of rape or incest; and some have delayed obtaining an abortion for a wide range of other deeply personal reasons.

2. I have lectured and written extensively on issues pertaining to obstetrics and gynecology, and have made numerous presentations concerning abortion and its importance to women's health care. I have published more than 40 articles in peer-reviewed journals. I am also a peer reviewer for several journals, including the New England Journal of Medicine, Obstetrics and Gynecology, and the American Journal of Obstetrics and Gynecology. I have been awarded several grants to conduct research about pharmacokinetics and pregnancy. A copy of my curriculum vitae is attached hereto as Exhibit A.

3. As part of my general practice of obstetrics and gynecology, I have been an abortion provider since 1976, when I started my residency. Although I perform

approximately 100 abortions a year, they constitute a small part of my practice. They are, however, a very important part of the comprehensive care I provide patients. I have performed hundreds of second-trimester procedures, almost all of which involved the dilation and evacuation ("D&E") or induction methods. I have observed and performed a few hysterotomies in exceptional circumstances and have observed at least one abortion by hysterectomy under extremely unusual circumstances. I have performed and taught many variations of both the D&E method and the induction method through twenty-four weeks LMP. The reasons that lead me to decide to do a D&E rather than an induction, or vice versa, include a wide range of variables such as medical problems experienced by the woman, her wishes, and, in the case of fetal anomalies, whether there is a need for an intact procedure to complete the diagnosis and help evaluate the risk of recurrence. Among the variations of D&E I have performed are several that resulted in a largely intact fetus. I am familiar with the use of a specific breech extraction technique -- called intact D&E or dilation and extraction ("D&X") -- to remove the fetus intact. See ACOG Statement on Intact Dilatation and Evacuation, attached hereto as Exhibit B. Although I have not used precisely that technique, I have read about this procedure and discussed it with other physicians.

4. I submit this declaration in support of Plaintiffs' Motion for a Temporary Restraining Order and a Preliminary Injunction. I submit this declaration on the basis of my expertise in obstetrical and gynecological procedures, including second-trimester abortions, and knowledge about the relative safety of various abortion procedures. The facts I state herein are based on my extensive clinical experience, personal knowledge, and study of the relevant medical literature and statistical data recognized as reliable in the medical profession.

5. It is my professional opinion that the new Illinois law banning so-called "partial-birth abortions" (hereinafter "HB 382" or "the Act") will cause severe and irreparable harm to women in Illinois. HB 382 will limit the discretion of physicians to provide abortion care using the procedures that, in their best medical judgment, are most appropriate in light of particular patients' circumstances. It has this effect for several reasons.

a. First, HB 382's definition of the banned procedures is so vague as potentially to encompass several methods, including the most common method of post-first-trimester abortions. Confronted with HB 382, physicians are faced with untenable choices: i) performing procedures under threat of criminal and civil prosecution; ii) ceasing to provide critical and constitutionally protected care; or iii) altering their practices, if they are able to do so, in a way that does not advance maternal health but only increases the cost and burden of the abortion procedure.

b. Second, HB 382's exception is dangerously narrow. It does not permit the performance of an otherwise banned procedure when the woman faces serious health risks if she continues to carry the pregnancy. Even when the woman's life is in danger, HB 382 imposes unacceptable and unsafe restrictions.

c. Third, under HB 382, a physician is liable for performing a so-called "partial-birth abortion" even if he or she did not intend to do so. The law thus exposes physicians to criminal prosecution and civil liability even when they inadvertently perform a so-called "partial-birth abortion," as they inevitably will on some occasions, given the numerous and unpredictable variables of obstetrical procedures.

d. Fourth, in the case of my minor patients, the only way for me to avoid civil liability under HB 382 is to violate these patients' confidentiality and dignity by proceeding only with the consent of their parents.

6. In each of the ways articulated above, HB 382 denies physicians the necessary discretion to provide medical care with the safety and health of the women patients as their foremost concern. If the physician adheres to the medically and ethically appropriate course of treatment, he or she risks criminal prosecution and imprisonment, numerous civil actions, and loss of the license to practice medicine. And if the physician adheres to the dictates of HB 382, the inevitable result will be to force women to undergo less safe procedures than their physicians would otherwise perform.

7. The remainder of this Declaration focuses on my clinical practice and describes the relative safety of abortion procedures that HB 382 probably prohibits and those that it may allow.

I. The Relative Safety of Abortion and Childbirth

8. Any discussion of the relative risks of different abortion procedures must be considered in the context of the overall safety of abortion. Abortion is one of the safest surgical procedures and, in terms of both mortality (death) and morbidity (medical complications short of death), it is many times safer than continuing pregnancy through childbirth.

9. Considering only abortions during the first trimester of pregnancy, when approximately 90% of abortions occur, a woman is more than twenty times more likely to die from continuing pregnancy through childbirth than from a first-trimester abortion. Considering abortions at all stages of pregnancy, a woman is approximately ten times more likely to die from continuing pregnancy through childbirth than from an abortion. Herschel W. Lawson et al., Abortion Surveillance -- United States, 1984-85, in CDC Surveillance Summaries, 38 MMWR (No. SS-2) 11, 30-32 (Centers for Disease Control, Sept. 1989); Rachel B. Gold, Abortion and

Women's Health: A Turning Point for America? 23, 29, 73 Notes to Figure 15 (The Alan Guttmacher Institute 1990).

10. The risk of morbidity also is low for abortion. Fewer than 3 per 1000 patients require hospitalization because of an abortion complication. National Abortion Federation, Summary of Annual Abortion Statistics 1995.

11. Although abortion overall is significantly safer than continuing pregnancy through childbirth, the risks associated with abortion increase as gestation advances. The risk of death from abortion increases approximately 30% with each week of gestation from eight weeks LMP to twenty weeks LMP. Herschel W. Lawson et al., Abortion Mortality, United States, 1972 through 1987, 171 Am. J. Obstetrics & Gynecology 1365, 1367 (Table II) (1994). The risk of major medical complications increases approximately 20% with each week of gestation from seven weeks onward. Christopher Tietze & Stanley K. Henshaw, Induced Abortion: A World Review 1986 103 (The Alan Guttmacher Institute, 6th ed. 1986).

II. Medical Problems Encountered During Pregnancy

12. I provide comprehensive obstetrical and gynecological care for my patients.

13. Some of my patients, particularly the ones undergoing second-trimester abortions, are ending wanted pregnancies. These terminations almost always are for medical indications.

14. The physiological, bio-chemical and anatomical changes that a woman endures during pregnancy are profound. Every organ and gland of the woman's body is affected.

15. Medical and surgical illnesses, some caused by pregnancy and some pre-existing which then complicate pregnancy, and which may necessitate that the physician

advise a woman to consider an abortion to protect her health, include:

- anemia and other diseases of the blood, including sickle-cell disease which is an enhanced burden to the pregnant women with pain attacks becoming more frequent and infections and pulmonary disfunction more common;

- urinary tract infections and disease, including acute pyelonephritis, which is one of the most frequent medical complications of pregnancy and which on occasion can lead to bacterial shock, producing serious health consequences and in some cases death;

- acute renal failure, commonly caused by premature separation of the placenta from the wall of the uterus, or hemorrhage or hypertensive disorders of pregnancy including eclampsia (sometimes referred to as toxemia of pregnancy);

- heart disease, producing higher risks of congestive heart failure, cardiac infarctions, and arrhythmias for pregnant women suffering from these problems;

- endocrine disorders, such as diabetes, which can either pre-exist pregnancy or be caused by pregnancy, and which often produce seriously adverse affects on the woman, including (i) a four fold increase in pre-eclampsia and eclampsia, (ii) more frequent and more serious infection, (iii) a

substantially larger fetus, which in turn increases the difficulty of labor and incidence of injury associated with labor and delivery, as well as the need for cesarean section, (iv) hydramnios (excessive amount of amniotic fluid), which may cause cardiorespiratory symptoms in the mother, and (v) hemorrhage;

- diseases of the nervous system, including epilepsy, which may be exacerbated by pregnancy and which may increase the frequency of seizures;

- liver diseases, some of which are induced by pregnancy, such as acute fatty liver of pregnancy, and which may prove fatal to the woman if delivery/termination of the pregnancy is not immediate;

- connective tissue disorders, such as systemic lupus erythematosus and rheumatoid arthritis, which may be exacerbated by pregnancy;

- chronic hypertension, which increases the risk of pre-eclampsia and eclampsia;
- respiratory disease, including asthma and pneumonia; and

- placenta previa and abruptio placentae, which increases blood loss and increases risk of chronic renal failure which, in turn, creates the need for blood transfusions and an attendant risk of blood borne infections.

- HIV present in blood stream, often involving tragic cases of women who come late for prenatal care, only to find out that they are HIV-positive. Having just learned that they have a potentially fatal disease, they cannot cope with delivering a baby who might also have it.

16. The availability of abortions is critical for the health of women with the conditions described above. Any denial or delay in care can, in some instances, compromise their well-being, even permanently.

17. Some other women decide to terminate their pregnancies after learning that the fetus has a condition that is incompatible with life or that will severely compromise its life and, in some instances, the woman's health as well. I perform abortions for women whose fetuses have genetic or congenital anomalies, some of which are fatal within days, if not minutes, of birth. Other fetuses might survive, but would be severely impaired throughout their lives. For example, I have performed terminations for women whose fetuses had trisomy 13 or 18, which are chromosomal anomalies and generally fatal; anencephaly, which is fatal because the fetus has no brain; and open spina bifida, in which parts of the neural system are outside the body. In such cases, the pregnancy has almost invariably advanced into the second trimester because most fetal anomalies are typically not even detected before that stage of pregnancy. Amniocentesis, the most common test for genetic anomalies, is usually performed at sixteen to eighteen weeks LMP, and the results come back two to four weeks later. If the results bring devastating news, many women are desperate to end the pregnancy. Even chorionic villus sampling to diagnose genetic anomalies is not performed until 10-12 weeks. The

results then are not available until a woman is into the second trimester of pregnancy.

18. Ready access to the best abortion care is thus critical for my patients' physical and psychological health. It is likewise essential that in providing care I have discretion to consider the full panoply of safe methods of abortion and to proceed with the method most appropriate for each patient.

II. Abortion Methods

19. For early abortions, most physicians, including me, typically use suction curettage, also called vacuum aspiration. In this procedure, the physician dilates the cervix – mechanically enlarges the mouth of the cervix -- and then removes the embryo or fetus and the other products of conception with a tube inserted into the uterus. The tube is attached to a vacuum generator, which provides the suction that empties the uterus.

20. At the end of the first-trimester and thereafter, when the fetus is often too large to remove simply by means of suction, physicians generally use one of two methods: D&E, which accounts for 95% of post-first trimester abortions nationally, or induction, which accounts for 5% of such abortions. Lisa M. Koonin et al., Abortion Surveillance -- United States, 1992, in CDC Surveillance Summaries, 45 MMWR (No. SS-3) 1, 32 (Centers for Disease Control, May 3, 1996). Intact D&E is a variation of D&E. Hysterectomy and hysterotomy account for less than 1% of post-first-trimester abortions.

21. At the outset of a D&E procedure, the physician dilates the cervix, typically over a period of many hours with multiple intracervical osmotic dilators made of either laminaria (seaweed) or a synthetic agent. The osmotic dilators absorb moisture and expand slowly in the cervix. When the cervix is sufficiently dilated, the physician removes the dilators and ruptures the membranes (the amniotic sac).

Then, using a combination of forceps, suction curettage, and sharp curettage, the physician removes the fetus. The calvarium (skull) is often too large to pass through the cervix whole, and the physician must compress it, sometimes with suction.

22. Usually, the physician removes the fetus in parts, but can sometimes remove it largely intact. Several factors determine how the procedure progresses -- including the size and orientation of the fetus, the amount of dilation, the condition of the cervix and uterus, and the patient's overall health and medical condition -- and the physician adapts his or her technique in light of the individual patient's needs.

23. For procedures performed later in the second trimester, a breech extraction variant of D&E sometimes referred to as intact D&E or dilation and extraction, D&X, may be used.

24. In an intact D&E, after removing the dilators, the physician extracts the fetal body intact, feet first, until the cervix is obstructed by the aftercoming head, which is generally too large to pass through the cervix. Then, using a sharp instrument, the physician creates a small opening at the base of the fetal skull and evacuates the contents, allowing the calvarium to pass through the cervical os.

25. Aside from D&E, the other common method of post-first-trimester abortion is induction, which entails using medications to induce premature labor. There are several variations of induction abortions. One is to inject a labor-inducing agent such as pitocin or oxytocin intravenously, continuously over many hours. A second method -- instillation -- involves injecting agents such as prostaglandins, prostaglandins and urea, or hypertonic saline into the amniotic sac. A third method involves introducing prostaglandins into the vagina or cervix. A fourth method involves intramuscular injection of prostaglandins. Many physicians use some combination of these methods to effect an induction abortion.

26. Inductions generally are not done before fifteen to sixteen weeks LMP. In the earlier part of the second trimester, inductions generally are less successful and may be difficult to perform. In addition, many physicians are trained and comfortable in doing D&Es at that stage.

27. Hysterotomy and hysterectomy are also used to terminate a pregnancy, but rarely. Hysterotomy is an incision made in the uterine wall through which the physician removes the fetus from the opened uterus. Hysterectomy, for the purpose of abortion, is the removal of the uterus with the pregnancy intact.

III. The Relative Safety of the Procedures

A. D&E Compared to Induction

28. According to statistics compiled by the Centers for Disease Control and Prevention (CDCP), D&E is generally the safest method of abortion available after the point in pregnancy at which suction curettage is no longer effective. These CDCP figures, although compiled in the 1980s, remain universally relied on in the medical community. See David A. Grimes & Kenneth F. Schulz, Morbidity and Mortality from Second-Trimester Abortions, 30 J. Repr. Med. 505, 509 (1985).

29. According to data compiled by the CDCP, the maternal mortality rate of induction procedures is almost twice that of D&E procedures, although the rates are comparable for post-sixteen-week procedures. Lawson et al., Abortion Mortality, United States, 1972 through 1987, 171 Am. J. Obstetrics & Gynecology at 1367-68 (Tables II & III). Compared to inductions, D&Es entail lower rates of maternal health complications, including fever, endometritis, retained products of conception, hemorrhage, and cervical injury. American College of Obstetricians & Gynecologists

(ACOG), Technical Bulletin 109, Methods of Midtrimester Abortion 3 (1987).

30. Another significant advantage of D&Es relative to inductions is that D&Es are available in the earliest weeks of the second trimester, while the induction technique is generally not effective prior to the sixteenth week after the LMP. Thus, unlike D&E, the induction procedure may require a woman to delay her abortion, which increases the risks involved. See Part I, above.

31. The safety of a D&E turns, however, in significant part on the skill and training of the physician. Because the procedure involves the use of sharp instruments inside the uterus, physicians without specific training in the D&E method should not use it.

32. Inductions are also safe procedures and have some advantages over most variants of the D&E technique. In particular, because they do not require the use of sharp instruments inside the uterus, inductions have a lower rate of uterine perforation. ACOG, Methods of Midtrimester Abortion 3. Inductions also may be indicated when an intact fetus is required for an autopsy to study fetal anomaly.

33. The main risk of induction stems from the fact that it involves the same medical complications as labor and delivery at full-term. Indeed, the contractions of premature labor typically last twelve hours, but can last up to thirty hours. Premature induction can be as physiologically stressful as induction at term. In addition, in my clinical experience, a separate procedure, usually a dilation and curettage, is necessary to remove the placenta in about 10% - 25% of inductions. D&E, by contrast, takes only about ten to thirty minutes and entails significantly less pain for the woman.

34. The physiological stress of the labor itself makes induction relatively more dangerous and is therefore often contraindicated for women with various medical conditions, such as cardiac ailments and active pelvic infections.

Induction is also contraindicated in the case of conjoined twins or where the fetus has certain anomalies, such as a hydrocephalus or when the woman has had a previous hysterotomy or classical (high) cesarean section. In such cases, induction can lead to uterine rupture, hemorrhage, and even death. ACOG, Methods of Midtrimester Abortion 2; Warren M. Hern, Abortion Practice 146 (1990).

35. Certain complications are associated with specific methods of induction. For example, if labor-inducing medications such as oxytocin are used, high doses are required because the uterus is less responsive to the inducing agents than it is at term. These high doses can cause severe metabolic disturbances and lead to potentially fatal heart, lung, and kidney problems. Complications associated with instillation abortions include respiratory complications that can require monitoring in an intensive care unit. Full-dose saline instillation entails a high risk of hypernatremia (concentration of salt in the woman's circulatory system) and of disseminated intravascular coagulation (DIC), which leads to hemorrhage in all major organs, including the brain. Urea instillation is safer than saline, but less effective; prostaglandin instillation is also safer than saline in terms of hypernatremia and coagulapathies, but has a higher rate of retained placenta, cervical trauma, severe gastrointestinal side-effects, infection, hemorrhage, and sudden death. Hern, Abortion Practice 124-25. Prostaglandins used intra-amniotically, intravaginally, or intramuscularly can cause vomiting, diarrhea, high fever, and migraines. Cardiac deaths have been reported with intravaginal and intramuscular use of prostaglandins.

36. Each specific induction method also has contraindications. For example, hypertension, sickle cell anemia, heart disease, kidney disease, and blood coagulapathy are all contraindications for saline instillation because systemic absorption of the saline can exacerbate those conditions. Similarly, prostaglandin instillations are

contraindicated for women with asthma, epilepsy, certain types of glaucoma, pulmonary hypertension, or hypertensive disease because systemic absorption of the prostaglandins can exacerbate those conditions. ACOG, Methods of Midtrimester Abortion 2; Hern, Abortion Practice 125. Prostaglandins used as an intramuscular injection or as a suppository are also contraindicated for asthmatic women.

B. D&E Compared to Intact D&E

37. Intact D&E is a variant of D&E; it has not been the subject of comparative clinical trials. However, based on my clinical experience, my review of the ACOG statement on intact D&E abortions and testimony in earlier cases challenging laws similar to HB 382, I conclude that it is among the safe options for abortion after the first trimester, with certain possible advantages, for some patients, over D&Es that involve fragmenting the fetus.

38. First, while there are no data comparing intact D&E with other procedures, physicians experienced in using the procedure have testified to their experiences with its safety.

39. Although we lack relevant safety data from comparative clinical trials and peer-reviewed studies, these physicians' low complication rates suggest that intact D&E is a safe procedure. Moreover, they reflect the common occurrence in medicine that individual physicians informally develop variations on procedures. Such variations become the subject of peer-reviewed studies and possibly evolve into common practice only after physicians -- such as McMahon and Haskell -- step forward in the first instance to describe their experiences.

40. The testimony of those physicians is not, however, the sole basis for my opinion that intact D&E is a safe option. In my own practice, [although I have not set out intending to perform specifically the breech extraction technique], I have performed many variations of D&E in which I have removed

the fetus largely intact. Thus, my own clinical experience also underlies my opinion of intact D&E.

41. Most important, intact D&E may reduce the risk of uterine perforation because it dramatically reduces the insertion of sharp instruments into the uterus, and because the fetus passes through the birth canal intact. In a D&E in which the physician disjoins the fetus, sharp instruments and sharp fetal fragments may damage the woman's tissues. An intact D&E reduces those risks. An intact D&E may also result in less blood loss and less trauma for some patients and may take less operating time, thus reducing anesthesia needs. Intact D&E may also have some advantages when a physician needs an intact fetus for an autopsy to assess the risk of recurrence of a fetal anomaly.

42. It may be difficult for a physician to predict with certainty that an intact method will be most appropriate in a particular procedure. If, for example, the physician grabs the fetal foot first and the fetus starts to pass intact, it may be safer and quicker to do an intact procedure.

43. Because an intact D&E may be the most appropriate method for some patients, the American College of Obstetricians and Gynecologists has taken the position that the physician's best medical judgment must govern the decision of which method to use, and that the state should not ban specific methods, including intact D&E.

C. <u>D&E and Induction Compared to Hysterotomy or Hysterectomy</u>

44. In almost all cases, either D&E or induction is far preferable to either hysterotomy or hysterectomy, both of which entail the risks of major surgery. Hysterotomy is no longer a generally acceptable method of abortion because of its high rate of morbidity. The morbidity associated with hysterectomy and hysterotomy is more than seven times that

associated with instillation abortion. Grimes & Schulz, Morbidity and Mortality from Second-Trimester Abortions, 30 J. Repr. Med. at 509. The mortality rate associated with hysterectomy and hysterotomy is more than seven times that associated with instillation abortion and more than ten times that associated with D&E. Lawson et al., Abortion Mortality, United States, 1972 through 1987, 171 Am. J. Obstetrics & Gynecology at 1367 (Table II). Hysterotomy in the second trimester involves cutting through the uterine wall when it is much thicker than it is at term. That, in turn, makes the procedure technically more difficult and entails greater blood loss than a cesarean section at term. Hysterotomy may cause uterine rupture during future pregnancies even prior to labor. Uterine rupture can be associated with catastrophic bleeding. To avoid the unacceptably high risk of rupture during labor, a woman who has had a hysterotomy must have a cesarean section in any future delivery. In addition to complete loss of fertility, hysterectomy entails greater surgical risk and prolonged recovery time.

45. Although the epidemiological and medical data bear on the assessment of the safety of various methods of pregnancy termination, the procedure that is generally statistically safest may not be the best procedure for a particular woman in light of her circumstances. When performing an abortion or any medical procedure, the physician determines the most appropriate method for a particular patient based on many variables: any underlying health conditions the patient may have; the exact stage of pregnancy; the condition of the fetus; the position of the fetus; the skill and training of the physician; and the facilities available. For abortion to remain safe, the physician must retain the discretion to make this judgment. HB 382, for the reasons described below, denies physicians this medically necessary discretion.

IV. HB 382's Unclarity

46. I have read HB 382, which bans so-called "partial-birth abortions." This law will harm my women patients and compromise my ability to practice medicine.

47. "Partial-birth abortion" is not a term understood by the medical community: there is no procedure known to physicians by this name.

48. The language of HB 382 is so vague that physicians, law enforcement, and potential civil plaintiffs cannot know what methods of abortion are proscribed. The ban on any procedure in which the physician "partially vaginally delivers a living human fetus before killing the infant and completing the delivery" is so broad as potentially to sweep within its scope any of the procedures I perform after the first trimester.

49. "Delivery" is given a broad meaning in obstetrics. Specifically, anything that is removed from the uterus--whether it be a baby, an intact fetus, a fetal part -- is "delivered." Consequently, even when a disarticulated part of a fetus is removed from the uterus, during one of my abortion procedures--i.e., when that part has been "delivered"--it is entirely possible, for all I can tell from reading HB 382, that there has been a "partial vaginal delivery" of a fetus.

50. In the course of any D&E, a part of the fetus may be vaginally "delivered" before the fetus dies and the procedure is complete. After I rupture the membranes, a fetal limb -- severed from or attached to the rest of the fetus -- may come through the cervical os and into the vaginal canal. I can neither predict nor control whether, in the course of the D&E, such an event will occur while the fetus is still alive. HB 382 makes me especially worried about later procedures, in which I rely principally on forceps. After rupturing the membranes, I typically reach in and pull a fetal part, often a leg, through the cervix. Again, that part may be detached from the fetal body, or still joined to it. In either case, the fetus may, for all I can tell from reading HB 382, be "partially vaginally

delivered" and may well still have a heart beat. As I read HB 382, anything I do at that point to complete the procedure could violate the ban.

51. HB 382 also could reach procedures that attempt, by one of several methods, to extract the fetus in as intact a state as possible. As discussed above, those techniques offer some advantages. For example, they reduce the number of times I must insert sharp instruments into the uterus, and thus may reduce the primary risk of D&Es, which is perforation of the uterus.

52. HB 382 is frightening because it exposes a physician to harsh criminal and civil penalties even if he or she did not intend to violate HB 382. The course of surgery and obstetrical practice is unpredictable, and the physician must alter his or her technique in response to the situation that evolves in the delivery or procedure room. A physician cannot make and adhere to a rigid plan; in adapting quickly to provide the safest care, a physician often proceeds in a way he or she did not intend at the outset.

V. The Impact of HB 382

53. HB 382 leaves physicians to fear that virtually any abortion could subject them to criminal liability.

54. Women's health would suffer greatly if physicians, lacking assurance that D&Es are not banned by HB 382, simply stop performing those procedures. Women would then have to travel out-of-state to obtain D&Es, which would increase the costs, cause delays -- and so make the procedure riskier -- and even prevent some women from terminating pregnancies altogether. Women also could stay in Illinois and attempt to obtain induction abortions. Again, I think women would suffer great harm if HB 382 forced them to undergo inductions when they would otherwise choose D&Es. Many of my patients, including the very young ones, the sick ones, those pregnant as a result of rape or incest, and

those terminating much desired pregnancies, would be traumatized by having to go through labor. Moreover, inductions are available only in hospitals or a hospital-like setting. Whereas D&Es at Illinois clinics range in price from approximately $350 for the earliest procedures to $600 to $700 for procedures at eighteen weeks, hospital abortions, including inductions, cost approximately $1000 to $3000. That cost is simply prohibitive for many of my patients. Finally, women for whom induction is contraindicated would have no choice in Illinois other than hysterotomy, which is an early, riskier version of a cesarean section and, in most cases, is unacceptably dangerous.

55. In order to continue performing D&Es, physicians could attempt to circumvent HB 382 by altering their practice, to the detriment of women's health. Physicians could try to ensure fetal demise prior to delivering any part of the fetus by trying to cut the umbilical cord first. That is not always possible, as a part of the fetus may protrude as soon as the physician ruptures the membranes. If the cord is not easily accessible, the physician would have to reach for it, blindly, which would pose an intolerable risk. Some physicians with special training use sophisticated ultrasound guidance to attempt to ensure fetal demise by injecting the fetal heart with potassium chloride or digoxin. Although I know how to use such procedures and have used them when medically appropriate, many physicians in Illinois do not or cannot do such procedures. Even if physicians learned to do such procedures, such injections are impossible for women with certain conditions. Further, a transabdominal injection poses the risk of bowel perforation, uterine laceration, bleeding and inadvertent injection into the woman of a toxic substance.

56. The exception to HB 382 provides no relief. The exception applies only in the extremely narrow circumstance in which a banned procedure "is necessary to save the life of a mother because her life is endangered by a physical

disorder, physical illness, or physical injury, including a life-endangering condition caused by or arising from the pregnancy itself; provided, that no other medical procedure would suffice for that purpose." This exception does not allow me to perform a banned procedure if it is necessary for the woman's health, but not her life. The woman could not obtain a banned procedure until she had waited for the pregnancy to become life-threatening. Moreover, the exception would essentially never apply: a banned procedure clearly may be the best choice for a woman whose life is in danger, but it would almost never be the *only* procedure that would save her life. A hysterotomy, for example, is in my view almost always an unacceptable method of abortion, but it would terminate the pregnancy and so save the woman's life.

57. The exception also compounds physicians' fear because it does not state that the physician can rely on his or her best medical judgment in determining that a banned procedure is necessary to save a woman's life. Thus, I do not know if I may be subject to prosecution if another physician simply states that I erred in my determination, or was unreasonable in my belief, that the procedure was necessary to save the woman's life. Again, HB 382 will endanger women's health: the moment when a pregnant woman's life may be at risk is no time for her physician to fear taking appropriate medical action.

58. Finally, HB 382's civil remedies section exposes me to civil suit and severe penalties unless my minor patients' parents' consent to the abortion. Were I to insist on such consent before any procedure that could fall within HB 382's potentially broad sweep, I would breach the confidentiality of the physician-patient relationship, offend my patient's autonomy, and cause harmful delay.

59. I see no purpose to HB 382 other than to make it more difficult and more dangerous for women to obtain abortions, and to intimidate physicians trying to practice

good medicine. HB 382 leaves physicians no choice but to compromise their patients' health or to face criminal prosecution and severe civil penalties. That choice is untenable.

/s/ Marilynn C. Frederiksen
Marilynn Conners Frederiksen

Subscribed and sworn to before me
this 24 day of November, 1997.

/s/ Beth Grogan
Notary Public

EXHIBIT H

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

THE HOPE CLINIC, MARILYNN CONNERS FREDERIKSEN, M.D., NORMAN A. GINSBERG, M.D., CASSING HAMMOND, M.D., LAUREN STREICHER, M.D., DAVID ZBARAZ, M.D., et al.,	)	Appeal from the United States District Court for the Northern district of Illinois, Eastern Division
Plaintiffs-Appellees,	)	
v.	)	
	)	No: 97 C 8702
JAMES RYAN, Attorney General of the State of Illinois, in his official capacity; RICHARD DEVINE, State Attorney for Cook County, in his official capacity,	)	Hon. Charles P. Kocoras
Defendants-Appellants.	)	

AFFIDAVIT OF CASSING HAMMOND, M.D.

1. I am a plaintiff in this lawsuit, and I submit this affidavit in support of Plaintiffs-Appellees' Motion for Stay of the Mandate. My qualifications are as set forth in my curriculum vitae, which is attached hereto as Exhibit A, and the bases for my opinions are essentially the same as those set forth in my original declaration in this case, filed on December 16, 1997, and attached as Exhibit B.

2. I have read the affidavit of Dr. Marilynn Frederiksen, who is my colleague at Northwestern Medical Center, and I submit this affidavit for the same reasons as those articulated in Dr. Frederiksen's affidavit in support of the motion to stay this Court's mandate. Because we practice together, the descriptions of Dr. Frederiksen's practice are equally applicable to my practice. I also agree with the facts and opinions articulated in Dr. Frederiksen's affidavit.

3. As indicated in my previous declaration, I have in the past attempted and performed abortions in which I have partially vaginally delivered an intact living fetus before taking steps that caused its death and completing the abortion. Declaration of Cassing Hammond, M.D. at ¶¶ 14-15. Indeed, I have performed or attempted intact extractions of a living fetus when providing care to the patients described below:

a. Jane Doe is a 29 year old woman who was referred to me for pregnancy termination at 20 weeks of pregnancy. She had had no prenatal care during this pregnancy. The initial blood tests revealed that she had leukemia. Part of that leukemic condition included significant "thrombocytopenia" and "thrombocytopathia," which means that she had very few platelets – the blood components needed for blood clotting – and the few platelets she had worked very poorly. She clearly needed to undergo the pregnancy termination to preserve her health although not strictly her life. Unfortunately, as a consequence of her illness she posed a very high risk of hemorrhaging during the procedure. Thus, I needed to choose a method of abortion associated with the least risk of perforation or laceration and their attendant higher risks of blood loss. Accordingly, I set out to do as intact a procedure as possible. I dilated the cervix and was able to achieve sufficient dilation to permit the intact extraction of the living fetus, which delivered feet first up to the cranium, which I then compressed, causing the death of the nonviable fetus, and completing the procedure.

An alternative to this intact procedure involving extraction of the fetus in segments would have exposed the patient to the risk of either laceration or perforation. Had either complication occurred, the resulting blood loss, given her poor clotting function, could well have led to serious health problems or even her death. Still, I would not have been able to say prior to performing the intact procedure that "no other procedure would suffice" to save her life. Let me explain. The risk of uterine perforation though real, is relatively small; laceration is more common, but the patient might well have survived these complications. The patient also likely would have survived an induction abortion. I have no doubt, nevertheless, that the intact procedure that I performed was safer for my patient than the alternatives in that it significantly reduced the relevant risks.

b. In another recent case, a 40 year old woman who had several children was referred to me at 21 weeks of pregnancy after an ultrasound revealed multiple fetal anomalies that suggested a Trisomy 13. (A trisomy is a chormosomal abnormality that occurs when three rather than the requisite two chromosomes are present in one of the 46 chormosomal pairs.) A Trisomy 13 is a devastating anomaly, associated with multiple physical anomalies and profound mental retardation. Most of these fetuses die either before the onset of labor or within the first year of life. In this case, I set out to do an intact procedure, thinking it most appropriate to protect the health of my patient and to perform as quickly as possible a procedure my patient considered to be emotionally very painful.

c. I recently also attempted to perform an intact abortion for a 28 year old woman who was developmentally delayed and referred to me at 22 weeks of pregnancy. The referring physician advised me that the non-viable fetus had been diagnosed with a trisomy 21 (Down's Syndrome). This patient's condition was complicated by a prior uterine myomectomy, with an incision that had

penetrated the endometrial cavity. In other words, her uterus was extremely fragile and at high risk of perforation with any instrumentation. Similarly, she faced an extremely high risk of having her uterus rupture—splitting apart with resulting massive hemorrhaging—if she underwent any contractions caused by spontaneously-occurring labor or induction. Her condition was further complicated by her obesity. I was able to extract the living fetus intact up to the calvarium before it fragmented, leading me to make a few additional insertions into the uterus to capture the remaining segments and complete the procedure. By setting out and working to remove the fetus intact I did, however, reduce the number of insertions and thus the risk to the patient.

d. I also commonly (nearly every month) see a patient who has spontaneously begun to abort her pregnancy during the second trimester. Recently I had a situation, similar to that described at ¶ 30 of my earlier submission, in which my patient came to see me with her cervix already dilated several centimeters, thus eliminating the need to serially dilate her cervix with laminaria. With my first insertion of the forceps into her uterus, I grasped the foot of the fetus and was able to extract the fetus, intact, out of the uterus until its head lodged at the internal os, or opening, into the cervix. At that point, I used a different forceps to put pressure on the fetal skull, and after compressing it sufficiently to assure its passage through the cervix without requiring additional dilation, I extracted the head of the now dead fetus and completed the procedure. Again, this was the safest and most sensible way to proceed with this case. Were I prohibited from removing the fetus intact, I would have had to artificially slow the procedure – an inadvisable step – so that I could ensure that the fetus was removed in pieces, an accommodation to the law that would serve only to increase the risk to my patient.

e. Even since this Court's decision on October 26, I have been contacted by the High Risk Obstetrics Service at my institution regarding a patient for whom an intact procedure would be highly appropriate. The patient is currently at 23 weeks of pregnancy. The pregnancy is severely complicated by a condition known as intra-uterine growth retardation ("IUGR") such that the fetus is only approximately the size of a 17 week pregnancy. There is no amniotic fluid, and in the maternal-fetal medicine specialist's view, it is highly improbable that the pregnancy will ever reach viability. I have been advised that the patient will likely choose to terminate the pregnancy. For all of the medical reasons stated above, and for reasons specific to the condition of this pregnancy and the fetus, I would prefer to do and would recommend an intact procedure because in my judgment, it is the safest possible abortion for this patient.

4. Given the nature of my practice, I fully expect to continue to see patients presenting circumstances such as those described above, and also patients presenting other serious medical circumstances, for whom I would want to do an intact abortion procedure, involving the partial vaginal delivery of an intact, living fetus, if possible, to avoid the risks and complications presented by alternative procedures.

/s/ Cassing Hammond, M.D.
Cassing Hammond, M.D.

Subscribed and sworn to before me
this 8th day of Nov., 1999.

/s/ Beth Grogan
Notary Public

EXHIBIT I

CURRICULUM VITAE

Cassing Hammond, MD

Office Address
680 North Lake Shore Drive
Suite 1000
Chicago, Illinois 60611

Home Address
440 NorthWabash #4905
Chicago, Illinois 60611

EDUCATION

5/82	Greenwood School, Springfield, Missouri Valedictorian
6/82 - 6/88	University of Missouri Six Year BA/MD Program Kansas City, Missouri BA in Biology; MD awarded 6/88
7/88	University of Rochester School of Medicine Rochester, New York Residency in Obstetrics and Gynecology

EXPERIENCE

8/95 - present	Northwestern University School of Medicine and Faculty Foundation Instructor, Department of Obstetrics and Gynecology
10/95 - present	Rehabilitation Institution of Chicago Consultant in Obstetrics and Gynecology

7/92 - 8/95	Highland Hospital of Rochester, Rochester, New York Department of Obstetrics and Gynecology Attending Physician
7/90 - 8/95	University of Rochester School of Medicine Rochester, New York Department of Obstetrics and Gynecology Clinical Instructor
7/92 -8/95	Women's Health Source Physician Associate (Providing women's health education through television appearances and lectures at community high schools, social groups health clubs, etc.)

AWARDS AND HONORS

Undergraduate Activities

Student Editor, "PRN", Medical School News Publication.
Founding Member, Medical School Peer Counselors
President and Performer, "On Call Players," Med School Performance Group
Task Force on National Board Preparation
Activities Director, Family Practice Forum
Representative, Medical School Advisory Council
American Medical Student Association

Honors and Awards

1997 Magnus P. Urnes Award, Excellence in Undergraduate Education
Residency Perinatology Award (Awarded Annually to Outstanding Resident)
Lemmon Company Award-Outstanding Med Student/ObGyn
Honor Societies; Phi Kappa Phi and Omicron Delta Kappa

Dean's List Six Years
University of Missouri Curator's Scholar
Joseph Collins Scholar
Who's Who Among American College/University Students

PROFESSIONAL SOCIETIES

Fellow, American College of Obstetrics and Gynecology
American Medical Association
Association of Professors of Gynecology and Obstetrics
Gay and Lesbian Medical Association
Gay and Lesbian Physicians of Chicago

ADMINISTRATIVE EXPERIENCE

Physician Organization Task Force-Highland Hospital of Rochester [Representative of ObGyn Department during formation of a Physician Hospital Organization]

Highland Primary Care Satellite Steering Committee [Physician Manager on committee overseeing the development of a primary care practice system.]

SCIENTIFIC PRESENTATIONS

Hammond C. Stika C. Frederiksen M. Keith L. The relationship of parity and outcome of twin gestation. 10th Juilee International Workshop on Multiple Pregnancy; Zakopane, Poland; September 1996

Hammond C. Stika C, and Frederiksen M: A Comparison Study of Vicryl Rapide and Chromic Catgut In Episiotomy Repair. 44th Annual Meeting of American College of Obstetricians and Gynecologists; Denver, CO, April 1996.

Hammond C: A Randomized Comparison of Intrapartum Patient Controlled Analgesia and Patient Demand Analgesia. Presented at Annual Residents Research Seminar: University of Rochester, Rochester, New York, June, 1992

Faculty Discussant/Shoulder Dystocia: Advanced Life Support in Obstetrics. (Course conducted by the Department of Family Medicine in conjunction with the American Academy of Family Physicians) The Nevele Hotel. Ellenville, New York, 1992)

PUBLICATIONS

Hammond C. Stika C. Frederiksen M. Keith L. The relationship between party and outcome of twin gestation. Archives of Perinatal Medicine of the Polish Society of Perinatal Medicine, 1996; 2:181

ONGOING STUDIES

Van Rooyen J. Stika C. Hammond C. Frederiksen M. A Randomized Comparison of Intravaginal Misoprostol and Laminaria for cervical ripening preceding second trimester abortion.

Hammond C. Ramos J. Slupik R. Valle R. A Randomized Comparison of Clinafloxacin and cefotetan for treatment of postpartum endometritis.

REFERENCES

Dr. Marvin Amstey
Professor of Obstetrics and Gynecology
University of Rochester
Rochester, New York

Dr. Marilyn Frederiksen

Associate Professor of Obstetrics and Gynecology
Director, Division of General ObGyn
Northwestern University
Chicago, IL 60611

BOARDS AND LICENSURE

Board Certified - American Board of Obstetrics and Gynecology (12-94)
Diplomate - National Board of Medical Examiners
New York Medical License
Illinois Medical License

EXHIBIT J

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

THE HOPE CLINIC, MARILYNN CONNERS FREDERIKSEN, M.D., NORMAN A. GINSBERG, M.D., CASSING HAMMOND, M.D., LAUREN STREICHER, M.D., DAVID ZBARAZ, M.D., et al.,	)	
Plaintiffs-Appellees,	)	CIVIL ACTION NO: 97 C 8702
v.	)	
JAMES RYAN, Attorney General of the State of Illinois, in his official capacity; RICHARD DEVINE, State Attorney for Cook County, in his official capacity,	)	
Defendants-Appellants.	)	

DECLARATION OF CASSING HAMMOND, M.D.

CASSING HAMMOND, M.D., being duly sworn, deposes and says:

1. I am a physician licensed to practice medicine in Illinois. I submit this declaration in support of Plaintiffs' Motion for a Preliminary and Permanent Injunction against

Illinois' law banning so-called "partial-birth abortions" (hereinafter, "HB 382").

2. I received an M.D. degree in 1988 from the University of Missouri and am a registered and licensed physician in Illinois. I am actively engaged in the practice of obstetrics and gynecology and am an Instructor in Obstetrics and Gynecology at the Northwestern University School of Medicine. I am a Fellow of the American College of Obstetrics and Gynecology and a member of the Association of Professors of Gynecology and Obstetrics. A copy of my curriculum vitae is attached as Exhibit A.

3. I provide my patients with a broad range of services, including general gynecologic and obstetric care.

4. As a part of my practice, I perform abortions at Prentice Women's Hospital, a part of Northwestern University Memorial Hospital. I perform abortions through 22 weeks of pregnancy, measured from the first day of the woman's last menstrual period ("LMP"). This is well shy of the onset of viability, which in a healthy pregnancy may occur at the beginning of the third trimester of pregnancy, at approximately 24 weeks LMP. I perform approximately 200 abortions per year, using either the suction curettage (also called vacuum aspiration) method, variations of the dilation and evacuation (D&E) method, or variations of the induction method.

5. I submit this declaration as an expert in obstetrical and gynecological procedures, including abortion. The facts I state herein are based on my extensive clinical experience, personal knowledge, and study of the relevant medical literature. It is my professional opinion that HB 382 will cause severe and irreparable harm to women in Illinois. HB 382 will limit the discretion of physicians to provide abortion care using the procedure that is, in their best medical judgment, most appropriate in light of a particular patient's circumstances. It will therefore force women to undergo less safe procedures than their physicians would otherwise perform, and might prevent some women from obtaining abortions altogether.

This declaration focuses on post-first-trimester abortion practice in Illinois, including my own practice, and on how HB 382 may affect abortion practice and women's health in Illinois.

I. Abortion Practice in Illinois

6. There are essentially six available methods for performing abortions: (i) administration of medical agents such as RU 486 and methotrexate, for early-first-trimester abortions; (ii) suction curettage (available typically in the first and early-second trimester); (iii) instrumentation procedures or dilation and evacuation ("D&E"), of which there are several variations (available typically between the early- and late-second trimester); (iv) induction procedures, of which there are also several variations (available typically in the late-second trimester); (v) hysterotomy; and (vi) hysterectomy.

7. Medical abortions induced by agents such as RU 486 are currently in clinical trials in the United States. They are not currently available except as part of these trials.

8. As a result of the limited availability of medical abortions, for the vast majority of first-trimester and for some early-second-trimester abortions, Illinois physicians use suction curettage. In this procedure, the physician mechanically dilates the cervix and then removes the embryo or fetus and the other products of conception with a suction tube or syringe inserted into the uterus. Because the fetus comes apart quite easily at this stage of pregnancy, it often is suctioned in fragments, while part of the "living" fetus (possibly including a heartbeat) remains in utero.

9. In some cases, for late-first-trimester and early-second-trimester abortions, a physician may still be able to use the suction curettage procedure, employing a larger cannula, such as a 16mm instrument.

10. However, in the large majority of post-first-trimester abortions, when the fetus is often too large to remove simply by means of suction, physicians are not able to use the suction curettage method. Instead, physicians (including me) generally use one of two other methods during this period: D&E, which accounts for the vast majority of second-trimester abortions in Illinois, or induction (also called instillation).

11. I use the D&E procedure as late as 22 weeks LMP.

12. In a D&E procedure, I dilate the cervix by inserting multiple intracervical osmotic dilators called laminaria. These dilators absorb fluid from the cervix and expand gradually over several hours. When the cervix is sufficiently dilated, I rupture the membranes that form the amniotic sac, either instrumentally or with suction. Next, using a combination of suction curettage and forceps, I remove the fetus. To make it easier to work in the uterus, I often grasp the cervical opening and pull it down close to the introitus (the opening of the vagina). This can reduce the length of the vaginal canal to as little as two inches. In some women with uterine prolapse, the vaginal canal is shorter because the uterus has prolapsed into the vagina, or even all the way to the introitus.

13. The process of removing the fetus commonly results in disarticulation of the fetus. I usually begin with suction, unless the fetus or fetal parts are blocking the cervical os. In that case, I begin by extracting fetal parts instrumentally (with forceps). Often in this process of extraction, fetal parts are being pulled into the vaginal canal while part of the "living" fetus (again, possibly including a heartbeat) remains in the uterus.

14. Sometimes the fetus comes out of the uterus intact, even when this is not specifically intended. The calvarium (skull) is often too large to pass through the cervix whole. To reduce the size of the calvarium, I may either collapse it with forceps or use suction to remove the contents.

15. Sometimes physicians will use a variation--actually, an evolution--of the D&E procedure called an intact D&E (or simply D&X), wherein the physician intends to bring the entire fetus, except for the calvarium, into the vaginal canal intact. Instrumental conversion of the fetus to a breech presentation is an essential step of an intact D&E according to the American College of Obstetricians and Gynecologists (ACOG), but not all physicians use the conversion step--and I myself do not do not use the step. In order to allow the calvarium to pass through the cervix, it is decompressed either with forceps or by inserting a sharp instrument into its base and draining the central nervous system.

16. An intact D&E procedure can sometimes be the easiest and safest D&E procedure, particularly in cases of fetal abnormalities, where geneticists often request that the fetus be removed intact to facilitate genetic testing. The intact D&E procedure reduces the risk of retained tissue, and requires less instrumentation in the uterus thereby reducing the risks of uterine perforation and cervical laceration.

17. The induction method is also a common method of second-trimester abortion. It entails administering medications to induce premature labor. Inductions in Illinois usually are performed in a hospital setting, often in cases involving fetal anomalies. In these pregnancies, the induction method is used in order to have an intact fetus for autopsy. Inductions at the hospital generally are performed by using varying combinations of the following: intravenous injection of oxytocin, continuously over many hours; introduction of prostaglandins into the vagina or cervix; insertion of laminaria into the cervix; and instillation of urea into the amniotic sac, by injection through the abdomen. Sometimes an additional separate procedure, usually a dilation and curettage, is necessary to remove the placenta or other remaining products of conception. Not all methods of induction ensure fetal demise prior to the commencement of labor. Although I

currently perform primarily suction curettages and D&Es, I have performed numerous inductions.

18. Just as with some D&E procedures, so in the case of some induction procedures, the calvarium may be too large to pass through the cervix whole. In that event, the physician must compress it, sometimes with suction. In some instances, the fetus may still exhibit signs of life prior to compression.

19. Inductions in Illinois generally are not done before 16 weeks LMP. Before that point, the uterus is relatively less responsive to labor-inducing medications, and any instillation procedure is technically more difficult and less successful. While there may be important reasons to perform an induction, inductions take longer than D&Es, often require a hospital stay, and entail the same level of pain and trauma as labor and delivery at full-term.

20. Many years ago, hysterotomy and hysterectomy were used to terminate second-trimester pregnancies. A hysterotomy is essentially a pre-term cesarean section: the physician makes an incision in the uterine wall and removes the fetus, through the abdomen, from the opened uterus. A hysterotomy results in an abdominal scar that is weaker than that resulting from a cesarean section performed at full-term. Women who have had hysterotomies are therefore at significantly greater risk of uterine rupture in subsequent pregnancies. Hysterectomy is the removal of the uterus and renders the woman sterile. Both of these methods involve major abdominal surgery with risks far greater than those associated with more commonly used abortions methods. They are currently used in Illinois only in extremely rare circumstances and, in my professional opinion, are almost never medically appropriate.

21. Although the D&E procedure is contraindicated in a few instances, it represents the safest abortion method available after the first trimester, with the lowest rate of maternal mortality, fever, and hemorrhage.

22. The medical risks associated with abortion, while low, increase with each week after the eighth week LMP. Because later abortions require more time and are more complicated medically, the fee for abortions also increases as the pregnancy progresses.

II. Potential Effect of HB 382 on Illinois Abortion Practice

23. I have read the new Illinois law criminalizing so-called "partial-birth abortions." Under HB 382, physicians who perform abortions are at risk of criminal prosecution, civil liability, and revocation of their licenses if they continue to use the methods of abortion that in their best medical judgment are most appropriate for many of their patients after the first trimester of pregnancy.

24. HB 382 bans so-called "partial-birth abortions," which the law defines as "partially vaginally deliver[ing] [] a living human fetus or infant before killing the fetus or infant and completing the delivery." The term "partial-birth abortion" is not a medical term. I know of no procedure called "partial-birth abortion."

25. HB 382 does not define "living." While I and many other physicians will make the assumption that "living" means "having a heartbeat," we understand that the legislature may have had another definition in mind, and that we make our assumption at our peril.

26. "Deliver" is understood broadly in obstetrics, to include the removal of anything from the uterus, whether it be a baby, an intact fetus, or a disarticulated fetal part. Consequently, as far as I can tell, when a disarticulated fetal part extrudes into the birth canal during an abortion procedure, a "partial delivery" has occurred.

27. As defined in HB 382, the term "partial-birth abortion" is so vague that it could encompass some of the late-first-

trimester suction curettage procedures, as well as many D&E procedures routinely performed in Illinois. Sometimes during such procedures, a part of the fetus passes through the cervical os before the fetus is fully removed. In some of these cases, the fetus may be "living" within the meaning of HB 382 -- whatever that meaning is -- when part of the fetus is within the uterus and part has emerged into the vaginal canal. When beginning a suction curettage or a D&E procedure, I cannot predict whether such a circumstance will arise, but there is always a possibility that it will.

28. Moreover, the proscription of HB 382 reaches so broadly as to encompass certain abortions performed by induction. During some of these procedures, for example, the umbilical cord may become entangled, necessitating that the physician cut it in order to complete the delivery. In those rare instances when the fetus is still alive at this stage, cutting the cord may cause its death. Again, no physician beginning an induction can know whether this complication will arise.

29. I personally have experienced many unexpected situations that called for immediate medical intervention, in which the prohibitions (and penalties) of HB 382 would almost certainly (as far as I can tell) be triggered. I describe one such typical situation.

30. A patient of mine had a desired pregnancy. She was at approximately 21 weeks LMP when her membranes prematurely ruptured. In essence, her body had begun to abort the pregnancy spontaneously. She came to me immediately. She understood that she had no choice whatsoever but to abort the fetus, and that the fetus was not viable and had absolutely no chance of surviving outside the womb.

31. Because of the risk of infection, the medically indicated course of action in such cases almost always is to complete as soon as possible what had begun as a spontaneous abortion.

32. Because of the gestational age of the fetus, I determined that a D&E procedure was the medically most

appropriate procedure. During the procedure, a fetal part extruded into the birth canal. I believed that, at that moment, the fetus still had a heartbeat.

33. Had HB 382 been in effect at that time, I believe that I would have committed the felony of "partial-birth abortion" no matter how I completed the procedure. This is because, as I understand HB 382, it prohibits a physician from causing fetal demise and completing the abortion after a fetal part (whether or not disarticulated) enters the birth canal. And because the situation I was presented with was one where a fetal part had extruded into the birth canal while there was (probably) still a fetal heartbeat, any continuation of the procedure would have resulted in fetal death after "partial delivery."

34. Personally, I am uncertain what I would do in a situation like the one I have just described, if HB 382 were in force at the time. Although I would like to state that I will obey the law whether or not it suits my particular political philosophy, I am uncertain how any physician could practice obstetrics without periodically violating HB 382--particularly in emergency situations like the above. Simply put, all physicians, regardless of their political views, will frequently have to violate this law in order to provide standard and essential obstetric care for their patients.

35. Notwithstanding what I believe virtually all physicians would do in certain emergency situations, I also believe that, faced with such extreme exposure to criminal and civil sanctions, many physicians who interpret HB 382 as I do would simply refuse to continue providing elective abortion services in Illinois.

36. Even if I took a more sanguine view of HB 382 and took it only to prohibit intact D&Es where the physician compresses the calvarium and evacuates its contents to complete the delivery, I would still not be able to avoid triggering HB 382 in some situations very much like the one described above unless I were willing to subject my patient to

serious risks to her life and health and permanent restrictions on her future fertility.

37. If, for example, the fetal head became entrapped while I was completing what had begun as a spontaneous abortion, I would normally crush the skull. However, to avoid HB 382, I would need to consider doing one of the three following procedures:

a. I could make a so-called Duhrssen's incision, where the cervix is incised and cut in order to make it larger. This would facilitate delivering the fetus without having to compress the calvarium. However, doing this puts at risk any future childbearing for the woman, and increases the risk to her of health complications, including severe blood loss with possible need for transfusions, and usually provides no medical benefit. Further, there would be no benefit whatsoever to the fetus, who would expire no matter what measures were taken.

b. I could perform a hysterotomy, or I could perform a hysterectomy. But, as indicated above, these involve very serious risks to the woman and usually no medical benefit. And again, there is no possible benefit to the fetus.

38. All these options prolong a situation that is emotionally and physically painful to the woman, and impose increased risks to her health, while providing no medical benefit to the fetus. They are "artificial" options that the physician would need to consider solely in order to avoid potential liability under HB 382. They are almost never options that a physician, considering only what is medically indicated, would elect to pursue.

39. Putting aside medical emergency situations, and considering only the situation of elective abortion procedures, physicians could attempt to avoid violating the terms of HB 382 by taking steps during the abortion procedure to ensure, to the maximum extent possible, fetal demise before any part of the fetus passes through the cervical os.

40. One possible approach would be for physicians to attempt to inject the fetus prior to beginning the procedure with a substance such as digoxin to trigger cardiac arrest. I myself have not had experience with such injections. Most gynecologists are not trained to perform this procedure, and I was not so trained. In fact, our residents at Northwestern are not routinely trained to perform the procedure. Moreover, due to the size of the fetal heart in most cases, it is absolutely essential that those few physicians who are trained in the procedure employ highly sophisticated ultrasound guidance. The necessary ultrasound machinery costs in excess of $30,000, and is thus only realistically available in hospitals or hospital-like settings--and certainly not in the typical outpatient clinic. Finally, even with the availability of such machinery, a physician must not employ this procedure until he or she has observed it on many occasions, and has had significant training in the procedure.

41. There are some women, such as women with heart conditions, for whom such injections would be contraindicated due to the substances injected. And, as with any medical procedure, performing the injection carries risks. For example, with a woman who has previously had abdominal surgery, there is a risk of puncturing the bowel in the course of the injection, and thus of serious infection and possibly death. There is also a small risk of puncturing a vein or artery, which could lead to internal bleeding. In addition, the added procedure of inserting a large needle through the abdomen would add to the pain, discomfort, expense, and length of the procedure.

42. Alternatively, to ensure fetal demise, physicians might try to cut the umbilical cord while the fetus is entirely in utero. In my experience, however, this is not always possible, and the physician cannot always know if he or she has succeeded in cutting the cord. Depending on the location of the cord within the uterus, searching for the cord with an instrument or suction

tube could unnecessarily increase the risk of uterine perforation and other complications for the woman.

43. Even in the context of non-emergency elective procedures, there is no benefit to the fetus to be derived from ensuring fetal demise prior to beginning the procedure, and there are usually increased risks to the woman. Here too, HB 382 would be forcing physicians to take what usually would be medically inappropriate, or unnecessary steps, solely to avoid its strictures, and with no medical advantage to be gained.

44. In sum, HB 382 leaves physicians with only unreasonable alternatives: to risk arbitrary prosecution and civil lawsuits for providing medically accepted, quality care; to stop providing medical services to patients needing abortions; or to perform abortions in a manner that, in the physician's best medical judgment, is not called for by medical standards and that will still leave some women without critical care.

Dated this 16th day of December, 1997

/s/ Cassing Hammond, M.D.
Cassing Hammond, M.D.

Signed and sworn to before
me this 16th day of December, 1997

/s/ Beth Grogan
Notary Public

No. 99-xxxx

IN THE

Supreme Court of the United States

HOPE CLINIC, et al.,

Petitioner,

v.

JAMES RYAN, et al.,

Respondents.

RESPONSE TO EMERGENCY APPLICATION FOR STAY OR RECALL OF THE MANDATE OF THE 7TH CIRCUIT COURT OF APPEALS

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RESPONSE

I. Because the Seventh Circuit Has Recalled Its Mandate and Restored to Its Calendar for Reconsideration the petitioners' Previously Filed Motions for Stay, the Supreme Court Need Not and Should Not Entertain Petitioners' Emergency Application for Stay or Recall of the Mandate

On November 19, 1999, after the petitioners filed with this Court their Emergency Application for Stay, the Seventh Circuit, on its own initiative, recalled its mandates in both *Hope Clinic v. Ryan*, No. 98-1726 (involving Illinois' partial-birth abortion ban) and *Christensen v. Doyle*, Nos. 99-2528 & 99-2533 (concerning Wisconsin's partial-birth abortion ban) and restored to its calendar for reconsideration the motions for stay previously filed with that court. See Respondents' Exhibit A. As of the time of the filing of this response on November 22, 1999, the Seventh Circuit has not released a decision on its reconsideration of the motions for stay. Consequently, the petitioners' request that his Court issue an interim stay or an order directing the Seventh Circuit to recall the mandate requests a meaningless act. The Seventh Circuit has already recalled its mandate. Furthermore, the request for a stay of the Seventh Circuit's mandate by a Justice of the Supreme Court no longer "set[s] out with particularity why the relief sought is not available from any other court or judge." S. Ct. Rule 23.3. Petitioners have not shown (indeed, had at the time of the filing of their application no cause to attempt to show) the "most extraordinary circumstances" that would warrant this Court's consideration of an application for stay while a similar motion remains pending before a court of appeals. *Id.*

II. Should the Court Entertain the Application, It Should Deny the Stay.

A. The Petitioners Have Failed to Demonstrate that Lack of a Stay Will Likely Cause Irreparable Harm.

Despite all of the abortions performed in the quarter of a century since *Roe v. Wade*, 410 U.S. 113 (1973), petitioners are unable to reference a single incident in which access to a D&X procedure was necessary to preserve a woman's constitutional right to have an abortion. The reason for this is simple. According to the American Medical Association, "[i]t is a procedure which is never the only appropriate procedure . . . ." AMA Backs 'Partial Birth' Abortion Curb, The Washington post at A1 (May 20, 1997), Separate Appendix of Defendants-Appellants [Respondents] in 7th Cir. No. 98-1726 at B94-96 (emphasis added). The American College of Obstetricians and Gynecologists, an organization which advocates against restrictions on its physician members, has candidly acknowledged that there is no circumstance where the D&X procedure "would be the only option [available] to save the life or preserve the health of the woman." Petitioners' Exhibit G at 2. The petitioners-physicians Frederiksen and Hammond, have very recently (and perhaps too conveniently in relation to their desire to reverse the Seventh Circuit's decision) changed their practices (or their affirmations) to allow them to state that they now do D&X or D&X-like procedures. However, they remain unable to state that they have ever seen a situation where the D&X procedure was necessary to save the life or health of a woman despite their lengthy experience in providing abortions at a very large and prestigious urban hospital. *See* Petitioners' Exhibits D & H. (*Compare* Petitioners' Exhibits D & H *with* Petitioners' Exhibits F & J to observe the petitioners' shifting posture.)

In order to make an argument that there is potential for irreparable harm, the petitioners first attempt to expand the scope of the statutory ban. They reference "[t]he imprecision and potential breadth of the Illinois ban," suggesting that it would expose physicians to the risk of criminal prosecution "for performing the safest and most commonly available methods of abortion, including D&Es and some suction aspirations." Application at 14. This analysis depends on an abnormal interpretation of the statutory language that was rejected by the Seventh Circuit. As the Seventh Circuit noted, an analogous statutory ban in Indiana has apparently resulted in no decrease in the number of D&E procedures performed in that state. Petitioners' Exhibit A, slip op. at 20-21. The construction offered by the Illinois Attorney General and accepted by the Court of Appeals is far narrower than that contrived by the plaintiffs, both as to the description of the procedure banned and the requirement of the proof of knowledge. Petitioners' Exhibit A, slip op. at 10-15. Any concern that prosecutions might arise form events outside that core meaning, no matter how fantastic, were eliminated by the assurances of the Attorney General of Illinois made before the Court of Appeals, acting both in his role as chief legal officer of the State of Illinois and as a representative of a class that includes all of the State's Attorneys who might prosecute on behalf of the State. Petitioners' Exhibit A, slip op. at 17. Abortion providers should be particularly comfortable to practice in Illinois given the Illinois Attorney General's assurances and given the unusual additional protection ordered by Seventh Circuit—a precautionary injunction consistent with those assurances.

True, as the petitioners suggest, the precautionary injunctions are unusual and even unnecessary, but few citizens can proceed in their given vocation with greater confidence against unfair prosecutions than these abortion providers who not only have the statutory language to rely upon, but also have the word of all potential prosecutors

backed up by potential enforcement of a federal injunction. The petitioners' claim that they will be irreparably harmed by fear of unwarranted prosecution is particularly hollow in the context of this case.

B. The Petitioners Have Failed to Demonstrate that They Are Likely to Prevail Should Certiorari Be Granted.

The respondents do not deny that there is a possibility, perhaps a "reasonable probability," that certiorari would be granted in this case should the petitioners follow through with a petition. However, such a probability does not exist for the reasons set out by the petitioners in their Application at 4-7, but because of the great significance of this issue and the fact that the courts of appeals have ruled in different directions regarding similar statutory bans. In fact, this Court already has before it a petition for writ of certiorari seeking to reverse the Eighth Circuit's decision striking Nebraska's partial birth abortion ban. *Stenberg v. Carhart*, No. 99-830 (cert. docketed Nov. 15, 1999).

While respondents do not take issue with general proposition that certiorari might well be granted in this case independently or in relation with *Stenberg v. Carhart*, they point out that the petitioners have failed their burden to demonstrate the likelihood that the Supreme Court would reverse the Seventh Circuit's decision. For example, to make their lead argument, the petitioners cite to *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 75-79 (1976), for the proposition that this "Court long has held unconstitutional laws that prohibit safe methods of abortion prior to viability." Application at 7, 8. *Danforth* did not hold that states could not ban safe methods of abortion, but that it was unreasonable for a state to ban a safe method of abortion which at that time was the one most commonly used after the first trimester, particularly in light of the then

unavailability of a safe alternative method. 428 U.S. at 77-79.

Perhaps recognizing the degree to which they have overstated the holding of *Danforth*, the petitioners again repeatedly suggest that Illinois' partial birth abortion ban is "potentially expansive enough to ban the most common and safest abortion procedures prior to viability, including many common variations of the D&E as well as many inductions and suction aspirations." Application at 8; see also *id.* at 10, 11-13. For the reasons addressed in the portion of this response addressing supposed irreparable harm, that statement simply is untrue under a proper interpretation of the statute.

The petitioners also argue that this Court will reverse the Seventh Circuit and strike the ban because it lacks an exception for the woman's health. Application at 9-11. However, as previously mentioned, the medical community does not believe that the D&X procedure is ever necessary to save a woman's life or to preserve her health. *See supra* at 2. Consequently, absence of this procedure will not deny a woman her right to choose an abortion without risk to her life or health. Under this circumstance, the petitioners could not convince this Court to reverse the Seventh Circuit on this basis.

C. Other Equitable Factors Favor Denying the Stay.

On December 15, 1997, nearly two years ago, the people of the State of Illinois acting through their elected representatives banned partial birth abortions in Illinois. The abhorrence the general population felt toward this particular procedure was so strong the 29 other states passed similar legislation and both houses of congress voted for a federal ban. Despite having made this policy determination nearly two years ago in a matter of such obvious significance to the public, the ban has never been effective because a federal

trial court mistakenly issued an injunction. As then Justice Renhquist has stated: "any time a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury." *New Motor Vehicle Bd. v. Orrin W. Fox Co.*, 434 U.S. 1345, 1351 (1977) (Renhquist, J.). Granting the stay now requested by the petitioners will merely perpetuate a wrong and increase the injury alreadyn suffered by the People of the State of Illinois.

CONCLUSION

For the reasons set forth above, the respondents suggest that this Court should not entertain the application for a stay or recall of the mandate or should alternatively deny that application.

Respectfully submitted,

By: /s/ Joel D. Bertocchi / JSP .

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No. 99-xxxx

IN THE

Supreme Court of the United States

OCTOBER TERM, 1999

Hope Clinic, et al.,

Petitioner,

v.

James Ryan, et al.,

Respondents.

PETITIONERS' REVISED MOTION IN REPLY TO RESPONSE TO EMERGENCY APPLICATION FOR STAY OR RECALL OF THE MANDATE OF THE 7TH CIRCUIT COURT OF APPEALS

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1. Petitioner Hope Clinic et. al. respectfully moves this court for leave to file a two paragraph Reply to Respondent Ryan's Response to Emergency Application for Stay or Recall of the Mandate of the 7th Circuit Court of Appeals. This Reply is necessary to correct misrepresentations by the Respondents as to the record and the "assurances" offered at oral argument.

2. Respondents' suggestion that the reputable physicians who are the plaintiffs in this case have "too conveniently . . . changed their practices . . . to now do D &X or D &X-like procedures" (Defendants' Response to Stay Application at 2) is contrary to the record. In their original declarations that were filed at the beginning of this litigation, both Dr. Frederiksen and Dr. Hammond swore that they personally had performed numerous abortion procedures in which they partially vaginally delivered an intact or a largely intact fetus as part of the procedure. See Dr. Frederiksen's original Declaration at ¶ 3; Dr. Hammond's original Declaration at ¶¶ 27-33. Defendants also misstate the record when they claim that plaintiff-physicians have not identified a single situation in which the D&X procedure was necessary to save the woman's life or health. At ¶ 3(a) of Dr. Hammond's Affidavit in Support of a Stay, he details the circumstances of a woman patient who suffered from leukemia and for whom the intact procedure was the safest for the patient and posed significantly fewer risks to her than did alternative procedures.

3. Finally, to argue that the representations of the Illinois Solicitor General at oral argument are binding on the 102 State's Attorneys of Illinois who enforce the law (Defendants' Response at 3) is contrary to the allocation of prosecutorial power under the Illinois Constitution. *Investment Co. Inst. v. Camp*, 401 U.S. 617, 627-28 (1978) (citing *Burlington Truck Lines v. United States*, 371 U.S. 156, 168-69 (1962)) (interpretation offered by defendants'

lawyers on appeal are entitled to little weight). In any event, those representations were anything but clear or limiting of the statute's scope. The actual representations of the Illinois Solicitor General at the en banc oral argument were to the effect that the Illinois General Assembly had rejected the narrow ACOG definition of the D&X procedure because the "legislature wanted a statute that was as broad as possible" (Oral argument transcript at 16, attached hereto as Appendix A) and that there were many variations of an intact abortion procedure that could be prosecuted under the Illinois Act, including situations in which the physician "remove[s] a small non-critical part of the fetus" or "a procedure that did not involve conversion to a footling breech," (oral argument transcript at 2). See also *Hope Clinic v. Ryan*, No. 98-1726 (7th Cir. Oct. 26, 1999) (slip op. at 7). Dr. Hammond has done, and continues to perform, "D&X-like" procedures that do not involve conversions to a footling breech as demonstrated in the paragraphs to his declarations that are cited above.

WHEREFORE, for reasons set forth herein, Petitioner-physicians in the Hope Clinic ask that an order be entered allowing Petitioner to file a Reply to Respondent Ryan's Response to Emergency Application for Stay or Recall of the Mandate of the 7th Circuit Court of Appeals.

Respectfully submitted,

By: /s/ Colleen K. Connell
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HOPE CLINIC v. RYAN

98-1726

EN BANC ORAL ARGUMENT

TRANSCRIPTION OF THE AUDIOTAPED PROCEEDINGS had at the hearing in the above-entitled cause before the HONORABLE JUDGE POSNER, ROVNER, EASTERBROOK, COFFEEY, EVANS, and WOOD.

****

MR. BERTOCCHI: Good morning, your Honors. May it please the Court, my name is Joel Bertocchi, and I represent the State Defendants in this case, Attorney General Ryan, and the 102 State's Attorneys of Illinois.

Your Honors, the Illinois General Assembly passed a statute that was very limited in scope. It was limited to a single type of abortion procedure and applied then only when the doctor involved set out initially to perform that procedure.

The legislature acted, and the District Court had before it -- the legislature acted on reliable evidence that

demonstrated that there is no need for this procedure, for the health reasons or otherwise.

And in fact, even the Plaintiffs in their affidavits have never claimed to have done, tried to do, or desired to do a procedure that violates the statute. Nonetheless, the Plaintiffs respond as if the sky is falling. They ought --

JUDGE WOOD: Mr. Bertocchi, one of the things about the briefs in this case and the next case that I found less than helpful was that they don't quite seem to join issue. Because of course if this statute had perhaps for example followed the definitions of the American College of Obstetricians and Gynecologists about a D&X procedure, it wouldn't have looked like this. And perhaps it would have been easier to see that it was really just about one procedure.

But instead it defines certain things. And where I don't see the parties really joining issue is your whole argument proceeds from the premise that it really does

have this definition. Theirs proceeds from the premise that it really doesn't. And what I need is some closure on this because it describes steps. And their concern is that these steps will exist in a lot of abortions, not just D&X's.

MR. BERTOCCHI: I understand, your Honor. The statute is not limited to a D&X procedure consisting of the four elements as ACOG described them, although any procedure that is covered by the statute in terms of its physical actions is going to be extraordinarily similar to that procedure --

JUDGE POSNER: Why don't you describe what the --

JUDGE ROVNER: Well, then why doesn't the statute just use the four-part ACOG test if that's what the state means to ban?

MR. BERTOCCHI: Your Honor, I think the state means to -- as is frequently the case when legislatures draft criminal laws, I think they mean to prevent minor variations.

Certainly the statute would

have been more specific if they had adopted the ACOG test --

JUDGE POSNER: Why don't you describe them, what you think the statute does and does not prohibit.

MR. BERTOCCHI: Your Honor --

JUDGE POSNER: What is a minor variation for example?

MR. BERTOCCHI: Well, your Honor, a minor variation might be the removal of a small noncritical part of the fetus and then the intentional -- the knowing partial birth of the other 99.9 percent. A doctor might argue that was not the same procedure.

It might involve a procedure that did not involve conversion to a footling breach.

JUDGE POSNER: Wait. How's that possible?

MR. BERTOCCHI: I'm sorry. I don't understand, your Honor.

JUDGE POSNER: Well, how is that possible? I thought the difference between the D&X and the D&E was that in the D&X the

fetus is removed feet first.

MR. BERTOCCHI: The D&X as described by ACOG is -- that is correct, your Honor.

JUDGE POSNER: Well, if had been -- how -- I don't understand. How could it be done any other way?

MR. BERTOCCHI: Your Honor, it could be done -- it could, I suppose in certain circumstances be done if dilatation was sufficient head first.

JUDGE POSNER: Well, why would anyone do that? I mean, the death of the fetus is brought about by the destruction of the head.

JUDGE WOOD: But I thought under some definitions it might not be; that under this statute, you have to have partial vaginal delivery, that is to say the moment of part of the fetus, the living fetus, into the birth canal.

MR. BERTOCCHI: Correct.

JUDGE WOOD: Then an action to kill that living fetus and then the completion of

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delivery.

So where in this statute does it say anything about which part of the fetus' body comes into the birth canal first, and what kind of action, whether compressing the skull or anything else, is taken to effectuate the killing?

MR. BERTOCCHI: It doesn't say that in the statute, Judge.

JUDGE WOOD: So anything, any part of the body. So if the legs went into the birth canal and the entire fetus is still in tact and living, and then something is done to kill the fetus, perhaps cutting the umbilical cord or something that would be clearly fatal, and then the rest of the delivery, that's covered?

MR. BERTOCCHI: Provided that the doctor acts with the knowledge requirement that's contained in the statute.

JUDGE WOOD: Well, the doctor knows the doctor's going to kill the fetus, right?

MR. BERTOCCHI: Yes.

JUDGE WOOD: That's what the

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doctor's doing.
MR. BERTOCCHI: There's more to the knowledge requirement than that, substantially more, your Honor. And that's the principal flaw --
JUDGE WOOD: Where?
MR. BERTOCCHI: -- in -- well, your Honor, the statute makes criminal -- makes a violation of law knowingly committing a partial-birth abortion and then --
JUDGE WOOD: Right. In other words knowingly taking these three steps --
MR. BERTOCCHI: Right.
JUDGE WOOD: -- which you just agreed with me could be taken the way I described.
MR. BERTOCCHI: They could be. And if they were taken that way with -- if that was the plan from the beginning, then that would be a violation of the statute.
But the doctors in this case in their affidavits, only -- the closest they ever come to saying that they have ever wanted to do that is to say that they think

they have done it inadvertently, or they may have done it without being able to predict that they were doing to going to do it. Those circumstances cannot be prosecuted under this statute. You cannot violate it inadvertently --

JUDGE WOOD: But I don't understand if you begin the process and the fetus is still alive, and then you kill the fetus, you do something that will surely bring about the death of the fetus, that seems to me to describe a great number of D&E procedures.

MR. BERTOCCHI: Your Honor, as the Plaintiffs in their affidavit and as the medical literature in the record describes a D&E it does not. A D&E intends to bring about disarticulation and death in the uterus.

Now, I agree the doctors have said that that does not always occur. But that is what their plan is. And under Illinois criminal law, if that is what their plan is, they have to act with that knowledge at each of the three stages, including at the

beginning. And unless it is a substantial probability that that is going to occur, then it's not covered by the statute. This is a --

JUDGE WOOD: So if the doctor sets out at the beginning under this statute to partially vaginally deliver the living fetus but then to decapitate it and kill it in -- do something in the uterus that causes the death, the doctor is perfectly safe?

MR. BERTOCCHI: That's correct, your Honor. This only --

JUDGE WOOD: The State of Illinois prefers that. That's interesting.

MR. BERTOCCHI: Well, it's not a matter of preference, your Honor --

JUDGE WOOD: Sure it is.

MR. BERTOCCHI: It's not my statute. It's the way the general assembly drafted it. I think the general assembly --

JUDGE WOOD: But why isn't that partial vaginal delivery -- I mean, since we all like plain language, why isn't that partial vaginal delivery of a living fetus,

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taking a step to kill the fetus, and then completing the delivery?

MR. BERTOCCHI: Well, your Honor, I guess I would have to ask -- I have to ask you a little bit more about what the doctor planned and executed as the initial step. Because it is possible under those facts, but if the doctor's intention was to cause death in utero, which is the plan according to D&E definition and the plan according to induction --

JUDGE POSNER: Well, isn't that true in induction though?

MR. BERTOCCHI: Yes, I was just about to say in induction also, your Honor. I know it doesn't always turn out that way, but unless it's a substantial probability --

JUDGE POSNER: What, induction is illegal? I don't understand.

MR. BERTOCCHI: No. Induction is not illegal.

JUDGE POSNER: But an induc -- often it's the process of the -- you know, the contractions that kills the fetus, and

the fetus often dies in the vagina, isn't that true?

MR. BERTOCCHI: That is correct, your Honor.

JUDGE POSNER: So why wouldn't that be forbidden by the statute?

MR. BERTOCCHI: Your Honor -- well, actually I'm not sure that I can say often. I believe that it does happen. I don't think that that is the intention. And I know that the action --

JUDGE POSNER: Well, I don't under --

MR. BERTOCCHI: -- that the doctor takes --

JUDGE POSNER: I don't understand why you say it's not the intention. If the doctor's indifferent as to when death occurs or where death occurs, let's suppose in 10 percent of all inductions it occurs after the -- a part of the fetus has exited the uterus, why wouldn't that be enough for --

MR. BERTOCCHI: Your Honor, because under Illinois criminal law --

JUDGE POSNER: -- fraud?
MR. BERTOCCHI: Under Illinois criminal law you don't act without -- you don't act with knowledge unless you --
JUDGE POSNER: Well, wait a second. What if I throw cars -- I'm sorry. What if I throw stones at a car under a bridge, and I don't think I have a very good chance of killing a person, but I -- you know, I think it's about a 10 percent chance. I don't want to kill the person. I just like to throw stones. That's murder, isn't it?
MR. BERTOCCHI: Your Honor, if the murder statute depends on the same knowledge requirement, no, it's not.
JUDGE POSNER: But it --
MR. BERTOCCHI: It might be a lesser --
JUDGE POSNER: Wait a second.
MR. BERTOCCHI: It might be a lesser degree --
JUDGE POSNER: You just said it's not murder?
MR. BERTOCCHI: It might be a

lesser degree of homicide. But unless you -- unless you --

JUDGE POSNER: It think that's class --

MR. BERTOCCHI: -- have awareness of --

JUDGE POSNER: I think that's classic murder.

MR. BERTOCCHI: Your Honor, unless you have an awareness that there is a substantial probability -- this is in the statute. 720 ILCS --

JUDGE POSNER: Yeah. Well, recklessness, you know. Recklessness. If don't have -- if you fire a machine gun into a lighted room, not indifferent to whether there are people there, and there are people there and you kill them, that's first degree murder, isn't it?

MR. BERTOCCHI: Your Honor, I don't believe that you can say -- it may be a form of homicide, but I don't believe that you -- I'd have to know more about the facts. How many people are in the room, how many times

you fire.

There are instances in the rock throwing example in which it might well be a lesser degree of homicide. But unless there is a substantial probability that the event you're talking about would occur, then it's not covered by this statute. You cannot inadvertently or recklessly violate this statute.

UNIDENTIFIED: Mr. Bert --

JUDGE POSNER: You can't recklessly violate the statute?

MR. BERTOCCHI: Not unless you're recklessly disregarding a substantial probability. Not in a 10 percent example.

JUDGE POSNER: Not in a 10 percent example? That's an amazing -- that's amaze -- you shoot into a lighted train, you have only a 10 percent chance of killing a person; you're lucky, you kill them, and you're not guilty of first degree murder you're saying?

MR. BERTOCCHI: Your Honor, I don't have the murder statute in front of me, but

if the murder statute proceeded --

JUDGE POSNER: It's not a matter of statute. It's a matter of elementary understanding of criminal law.

MR. BERTOCCHI: Your Honor, this case is all about the statute and about the construction of statute. You cannot get away from --

UNIDENTIFIED: Why don't we proceed (inaudible)

MR. BERTOCCHI: Thank you, your Honor.

JUDGE ROVNER: Mr. Bertocchi, if a physician knows that in 30 percent of D&E's the fetus may be largely intact throughout the process and that the fetal skull will have to be reduced to complete the procedure; does that physician knowingly violate the Illinois law?

MR. BERTOCCHI: Your Honor, I haven't seen anything in the record, including the Plaintiffs' affidavits, that uses a 30 percent figure.

JUDGE ROVNER: I --

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MR. BERTOCCHI: But again --
JUDGE ROVNER: It's a hypothetical.
MR. BERTOCCHI: I'm sorry. I didn't realize that. I thought you were referring to something. I apologize.
Your Honor, I guess that depends on what substantial probability means, and I don't think it would, I have to say, because it's not even simply a probability which I would interpret as meaning more likely than not.
It's not -- it doesn't sound like in that instance that that is what the doctor expects to happen according to normal medical practice. It may well occur in 1 percent of the time, in 30 percent of the time. But unless it's a substantial probability, it's not covered.
JUDGE POSNER: There's a lot of talk in the briefs about an intact fetus. What is your understanding of an intact fetus?
MR. BERTOCCHI: An intact fetus, your Honor, is a fetus that is in the form

that nature made it. It is whole --

JUDGE POSNER: Well, what if it's very deformed?

MR. BERTOCCHI: It is still whole, your Honor.

JUDGE POSNER: What if it has no head?

MR. BERTOCCHI: It's whole as to that fetus. But if it has no head, it's probably dead already, and the statute doesn't apply.

Your Honors, the construction of this statute that's presented by the Plaintiff violates four basic rules of statutory construction: They read the statute broadly instead of narrowly; they construe words subjectively instead of according to the plain language or legislative history; they break the statute up into words; and they ignore, as we've been talking about, the most critical term in the statute which is the knowledge term.

If this Court construes this statute properly, the result is that it will

not infringe on protected medical procedures that are required to permit access to abortion as is required by the Supreme Court's case law.

JUDGE WOOD: What if we thought though that you were offering a reading of the statute, but the legislative history and the background to one side, there are other equally reasonable readings? This Court has no authority to give a narrowing interpretation of the state law.

MR. BERTOCCHI: Your Honor, indeed this Court has an obligation to give a narrow interpretation of the state law if it will save constitutionality of the statute.

JUDGE WOOD: How can we tell the State of Illinois, the Supreme Court of Illinois what an Illinois statute means? We can hope that we got it right; but if the Supreme Court of Illinois tomorrow were to get this case, they could say 7th Circuit doesn't know what it's talking about.

MR. BERTOCCHI: And if that happens, your Honor, the parties in that case

would have recourse to the Supreme Court of the United States. But in the meantime, the Plaintiffs, having chosen this procedural vehicle, have placed the obligation on the federal courts. Your --

JUDGE WOOD: But we can't change the statute. We can give it a faithful reading, but we cannot construe words beyond what their meaning will carry.

MR. BERTOCCHI: Your Honor, I believe that the construction that I am offering and about to offer is the -- is not strained. It is consistent with both the legislative history, and -- well, more importantly, with the plain meaning of the language --

JUDGE WOOD: Could we just stick with the words since there are some members of our Court anyway who --

MR. BERTOCCHI: Fine.

JUDGE WOOD: -- are skeptical about legislative histories.

MR. BERTOCCHI: Your Honor, the Plaintiffs suggest that partial modifies

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fetus. That is just a violation of the rules of grammar more than anything else. The word "partially" modifies vaginally delivers. There is no reference in the statute to a fetus that has been dismembered.

The word living is understood by everyone in all these cases and the doctors in this case as having a heartbeat. The term fetus or infant, as I indicated, is whole or intact.

The Plaintiffs very snidely make reference to Louis Carroll and suggest that the State is trying to read the word intact in. But I would submit that an intact -- a reference to any object refers to that object in its intact form unless you say otherwise.

JUDGE WOOD: But the fetus could easily be living if it didn't have a leg for example. There are all sorts of war veterans who tragically lost limbs, and they're very much alive and living people. And I don't see why a fetus couldn't be too.

MR. BERTOCCHI: That's --

JUDGE WOOD: Why does it have to be intact?

MR. BERTOCCHI: It could be, your Honor, but that's not the way the Illinois General Assembly passed this statute.

JUDGE WOOD: But that's not what it says. It just says a living human fetus. It might be not intact. It's still a living human fetus.

MR. BERTOCCHI: Your Honor, I think intact is a more natural reading than parts. Parts is the word that has to -- (Inaudible)

JUDGE POSNER: Are you saying the abortion doctor could snip off a limb of the fetus in the uterus and then perform a partial-birth abortion?

MR. BERTOCCHI: Your Honor, if the doctor was doing so as part of a planned D&E procedure, yes. If the doctor was doing so to evade --

JUDGE POSNER: So we're beyond --

MR. BERTOCCHI: -- the statute --

JUDGE POSNER: So we're beyond intact now at least.

MR. BERTOCCHI: Well, your Honor, you pose an interesting question of Illinois criminal law as to whether he would be guilty or innocent. But if that procedure were being done, the example we used when we were talking about this case was a toe. And in that instance, that would be someone acting to evade the law --

JUDGE POSNER: Let's take the other --

MR. BERTOCCHI: -- and not to perform the D&E.

JUDGE POSNER: Let's take the other side of it. Suppose the doctor doesn't have an intention to perform a partial-birth abortion when he begins the procedure but changes his mind and decides -- as the fetus is emerging from the uterus, he decides to kill it.

MR. BERTOCCHI: He didn't plan it at the beginning, your Honor, then the mental state does not apply to all three stages. It must be present at all stages. That's simple Illinois criminal law that governs this

statute.

Your Honors, I believe under the circumstances that I should save the remainder of my time for rebuttal.

JUDGE POSNER: Okay. Thanks, Mr. Bertocchi. Ms. Connell.

MS. CONNELL: Good morning. May it please the Court, Colleen Connell for the Plaintiff-Appellees in the Hope Clinic case.

The essence of this case is whether the Constitution permits a state to outlaw medical techniques that are critical to preservation of the life and health of pregnant women. The --

JUDGE WOOD: Ms. Connell, if this statute really did just cover the D&X procedure as defined by the ACOG, is there any way you could be here under the records that have developed in these two cases?

MS. CONNELL: Yes, your Honor. First of all, I have to say that we emphatically reject the notion, even hypothetically, that the Illinois Act bans only the D&X procedure as defined by ACOG.

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And indeed Counsel's argument rebuts that notion as well.

But yes, we believe that a law that were to ban only the D&X procedure as narrowly defined by ACOG would still present constitutional difficulties. It would unconstitutionally and unduly burden the right of a woman to have an abortion because the uncontroverted evidence in this case, as well as our companion case, establishes that in some instances the D&X procedure may be the safest and most medically appropriate method of terminating pregnancy given the particular health circumstances of the woman at issue and basically the circumstances surrounding the termination.

JUDGE POSNER: But none of the Plaintiffs performs these procedures, does he?

MS. CONNELL: Actually, your Honor, they do. I think that the unconverted affidavits of the Plaintiff-physicians in this case, most particularly Dr. Hammond and Dr. Frederiksen, attest to the fact that they

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both perform intact procedures.

They may not necessarily perform intact procedures as defined by ACOG, most particularly the deliberate instrumental conversion of the fetus to a breach presentation, but they do perform intact procedures of the fetus, particularly during the second trimester of pregnancy.

JUDGE POSNER: When you say intact procedure, you mean the fetus is killed in the vagina?

MS. CONNELL: When I say intact procedures, your Honor, what the record here establishes is that the cervix is dilated, and then the fetus is extracted, or part of the fetus is extracted into the vaginal intact.

In many instances, as our affidavits establish, the fetus is still living, with living being at least interpreted by my Plaintiff-physicians to mean the presence of a heartbeat, your Honor.

In some instances, however, particularly if the pregnancy termination is

because there might be some health consequences affecting the fetus, the fetus actually may be dead at the time that the abortion is performed.

JUDGE COFFEEY: Is there any proof that any of those have been ill or damaged when they are doing them?

MS. CONNELL: Yes.

JUDGE COFFEEY: In this record?

MS. CONNELL: Judge Coffeey, I am not sure I understand your question. Is there any proof what?

JUDGE COFFEEY: Is there any proof in this record that any of these that they have killed were damaged at the time they did kill them?

MS. CONNELL: If you mean damaged by the existence of a fetal anomaly, yes, there is. Dr. Frederiksen's affidavit in particular, as well as the affidavit of Beth Fine, attest to the fact that almost all of Dr. Frederiksen's second-trimester abortions are for the reasons of either severe maternal health considerations or because the fetus is

suffering --

JUDGE COFFEEY: Severe maternal now.

MS. CONNELL: Or --

JUDGE COFFEEY: I'm talking about the child.

MS. CONNELL: Or because the fetus is suffering from lethal anomaly.

Dr. Frederiksen talked about such diseases as Tay Sachs disease. Ms. Fine talked about the presence of dwarfism. The diagnosis of many of the trisomies that would be inconsistent with life --

JUDGE COFFEEY: No. If they say but they have had that problem?

MS. CONNELL: They have had that problem, and that is the reason for most of Dr. Frederiksen's second-trimester abortions, your Honor.

The Act at issue bans conduct that would cover or that is actually performed in all of the safe and commonly available methods of abortion, the D&E, most particularly.

In fact, Counsel for the State conceded that if a physician were to start doing an abortion and were at the beginning stage of the abortion to basically take off a small part of the fetus, as for example a toe, and then proceed with the remaining steps of the procedure of partially vaginally delivering that living fetus, proceeding to kill the fetus and complete the delivery, that would be a covered procedure that would be banned by the Act, and that would subject Plaintiff-physicians to criminal prosecution.

That conduct describes a D&E. It describes many D&E's. And the knowing scienter requirement does not rescue the statute or provide any comfort for Plaintiff-physicians who fear criminal prosecution. That is be --

JUDGE EASTERBROOK: Counsel --

MS. CONNELL: Yes.

JUDGE EASTERBROOK: -- what has happened in those states where statutes of this general kind have gone into force? Have the fears that you express in this case come

to pass in those states?

Indiana for example has a statute that's identical to Illinois'. It's been enforced now for two years and four months. Have there been any prosecutions of the kind you fear?

MS. CONNELL: Your Honor, I don't know the answer precisely to your question. But I do know --

JUDGE EASTERBROOK: Has there been any change in physicians' practices in Indiana?

MS. CONNELL: Your Honor, I don't know that. I don't represent plaintiff -- I don't represent any physicians in Indiana challenging that law.

JUDGE EASTERBROOK: But one would think that the weight of these fears could be checked against what's actually happened in the states that have these laws.

MS. CONNELL: Well, your Honor, I would say one thing about Indiana. First of all, there is only a single provider of second-trimester abortions in Indiana, and

that is the University of Indiana clinic serving hospitals. And they're all done as in-patient procedures.

I do not know, and nobody has put into record either in our case or in the companion case any evidence as to whether the plaintiff -- or whether the physicians in Indiana at the University hospitals have resorted to such techniques as injections of a substance toxic to the fetus before starting their second-trimester abortions. We just don't know that, your Honor. But I would submit --

JUDGE ROVNER: Does the record show how many women have traveled from Indiana to Illinois to obtain abortions?

MS. CONNELL: No, it doesn't, your Honor. The knowing scienter requirement does not rescue this statute from unconstitutionality. Knowing as defined under Illinois law is basically acting with awareness of the general nature of one's conduct. The unrebutted testimony below establishes that all the Plaintiffs act with

awareness of the general nature of their behavior in these abortion procedures.

JUDGE WOOD: Now, Ms. Connell, I take it just to turn for a moment to standard of review, that the meaning of the term knowing, as Illinois uses it in the statute, is surely a legal question that the District Court resolved and that we will take our own look at.

MS. CONNELL: Yes. That is accurate. But my point, your Honor, is that the knowing requirement or the knowing scienter requirement doesn't really provide any comfort for the Plaintiff-physicians here. Because when performing an abortion, they act knowingly as to each of the elements of conduct that the State contends are essential for showing the performance of a partial-birth abortion; namely, they partially vaginally deliver a living fetus. They know that in many instances.

They know the fetus is alive at the outset of the procedure when they start doing it. They know and they act with

that knowledge that their conduct during the course of that abortion, after they have partially removed the fetus or part of the fetus from the vagina, will result in the demise of the fetus.

And finally, they complete the abortion or complete the delivery. The knowing requirement is not contrary to the argument made by the State, some kind of fixed intent state that you do or you set out to do at the beginning of the procedure and then --

JUDGE COFFEEY: How would you draft that statute then so it wouldn't be objectionable to you?

MS. CONNELL: Your Honor, if one were to draft a statute that would at least have a chance --

JUDGE COFFEEY: No. But how would you draft this statute?

MS. CONNELL: I think that you could draft -- I think Judge Wood had the question initially to the statement. She said why not draft the statute like the

American College of Obstetricians and Gynecologists did. Define precisely the conduct that you think is part of the procedure you are seeking to ban.

That was not done here. And in fact, the State both in argument and in its brief specifically rejected any effort to do that because the State wants to preserve the wiggle room for its prosecutors to prosecute what it describes as variations of the abortion procedure. The State doesn't want to limit its prosecutions to the D&X procedure --

JUDGE COFFEEY: You're telling us what they want --

MS. CONNELL: -- as defined by ACOG.

JUDGE COFFEEY: -- not -- then your answer is that they should follow the recommended procedure of the OB and GYN specialists; is that right?

MS. CONNELL: I'd say that's the starting point, your Honor. I think that there are two additional --

JUDGE COFFEEY: That's the finishing one.

MS. CONNELL: -- elements that you would need to do. I think you would absolutely have to, to meet constitutional standards, have a requirement that the ban have an exception for the health -- to preserve the health of the woman.

An unbroken line of Supreme Court authority from Roe to Casey demands as a constitutional imperative that the physician be allowed to retain the discretion to protect the health of the pregnant woman. I think another thing you would have to do is that you would have to limit the scope of the procedure -- or excuse me -- the scope of the ban to situations involving the post-viability period of pregnancy. Because prior to that, the State does not have a compelling or an important governmental interest sufficient to support a ban on a procedure unless it can show --

JUDGE COFFEEY: Why don't they?

MS. CONNELL: Because prior to

viability, the State has interests that would support such regulations only to protect maternal health and in an effort to persuade the woman not to have an abortion --

JUDGE COFFEEY: Well, what case law do you have to support that --

MS. CONNELL: I would cite Casey for that, your Honor. The State can attempt to persuade a woman after Casey not to have an abortion. Once the woman has decided to have an abortion, the State has no interest in forcing her to have that procedure by a method of abortion that would present additional health risks.

And so absent record evidence, which is lacking here in our companion case that the D&X procedure is actually dangerous to the health of the woman, the State cannot ban it. It does not have an interest.

The abortion is still going to occur by another method. The State can't make that -- make the doctor use a method that may be less than optimal or less medically appropriate for the woman given her

particular medical circumstances.

The Illinois statute is flawed from its outset. It uses very broad sweeping definitional terms that if read at face value encompass every safe and commonly available method of abortion starting with the suction aspiration, going to the D&E, going to the inductions because many --

JUDGE EASTERBROOK: It's certainly the case that the statute could be read that way. Is it your position that the State Supreme Court would be compelled to read it that broadly --

MS. CONNELL: Yes --

JUDGE EASTERBROOK: -- that no principles of interpretation would permit the State Supreme Court to read it more narrowly?

MS. CONNELL: Yes, your Honor. I'm absolutely taking that position for the following reasons. First of all, as the State of Illinois recognizes in its brief, the primary principle of statutory construction in Illinois is to give intent or give effect to the intent of a legislature.

The legislative intent here is pretty clear when you read the legislative history. The legislature specifically wanted to draft as broad a statute as possible. The legislature debated the vagueness of this statute and declined to clarify it.

The legislature here specifically rejected, voted down amendments that would have included a health exception to the ban. The legislature also voted down an amendment that would have limited the scope of this ban to post-viability situations.

JUDGE EASTERBROOK: Do you think this statute is more or less clear than 18 USC 242, the basic civil rights enforcement statute?

MS. CONNELL: Is that the one at issue in US versus Screws, your Honor?

JUDGE EASTERBROOK: That's the Screws statute where -- and you're -- if you know Screws, then you're familiar with the Supreme Court's interpretive strategy.

MS. CONNELL: I am.

JUDGE EASTERBROOK: It's the vaguest statute anybody could imagine. And the Supreme Court said but since it's got a mental state requirement in it, it can't be unconstitutionally vague.

And I understand Mr. Bertocchi to be making that line of argument, that this statute has a mental state requirement in it, so it can't be unconstitutionally vague.

MS. CONNELL: Yes, your Honor. But I think that the factual difference between the conduct that was at issue at Screws and the conduct that's at issue here requires a different outcome. At issue in Screws was whether the defendant law enforcement officers who arrested an African-American --

JUDGE EASTERBROOK: No. Screws --

MS. CONNELL: -- handcuffed him and then --

JUDGE EASTERBROOK: The Screws case is not limited to Mr. Screws. It upheld the validity of 242 as applied to everybody using a particular theory of interpretation. And what the majority says is it's got a mental

state requirement, so it can't be vague. The question is why doesn't that theory apply equally here?

MS. CONNELL: Because the Defendants -- or excuse me -- the Plaintiffs here don't know whether the conduct that the statute describes would outlaw each and every method of abortion. They are completely uncertain.

JUDGE EASTERBROOK: But if they're completely uncertain, then the State will never be able to prosecute them because in order to prosecute, it has to show that they know that their conduct violates this law.

MS. CONNELL: No. The State doesn't have to show that they know that -- what I interpret the statute as saying, your Honor, and perhaps I'm missing the question, is that the Plaintiffs here know that their conduct includes the elements that are described in the statute.

But they are uncertain, in part because of the construction given by the Defendants, as to whether engaging in that

conduct would subject them to criminal prosecution or not.

I think by way of contrast in the Screws case there should have been no question that, you know, beating up someone whose -- you know, whose hands were handcuffed with an eight-pound blackjack would violate the constitution --

JUDGE EASTERBROOK: But look. The Screws case is not limited to Mr. Screws. 242 has been applied to everybody else, and people don't go around saying oh, the Screws case is just limited to beating people with a blackjack. It doesn't apply here.

It's a holding at the level of principle by the Supreme Court, and that's the thing that is most -- most vital here.

Now, maybe what you're saying is the Supreme Court construed Screws to require knowledge of illegality and not knowledge of physical acts.

Your view must be that the Supreme Court of Illinois would -- couldn't construe the state law to require knowledge

of illegality as opposed to knowledge of the particular physical acts being taken.

MS. CONNELL: Yes. I think I would accept the construction, Judge Easterbrook. Thank you.

I would like to finish my answer to your question about whether the Illinois Supreme Court could construe this statute in a constitutional way.

The statutory construction law in the State of Illinois is pretty clear for the proposition that the Illinois Supreme Court will not read into the statute terms that weren't there, and particularly will not read into a statute limitations that were rejected by the legislature in a particular vote.

So in summary on that point, I think that the Illinois Supreme Court would not and could not construe this statute in a narrowing way that would preserve its constitutionally.

In summary, the Illinois act is unconstitutional in a number of respects.

It is unquestionably unduly burdensome of a woman's abortion right, because it on its face appears to outlaw all methods of safe and commonly available abortions.

It is also unduly burdensome of the abortion right because it does not contain the requisite health exception that the jurisprudence in the abortion area has demanded.

A woman's health has to remain a physician's paramount concern during the abortion procedure. And the Illinois act specifically leaves that out, does not allow a physician to take that into consideration.

The Illinois act also suffers from I believe vagueness that is incurable. So in summary, the Illinois statute is unconstitutional. The District Court properly held that it was unconstitutional on a number of grounds and declared that it was unconstitutional and could not be enforced. We ask that you affirm the District Court's opinion. Thank you.

JUDGE POSNER: Okay. Thank you,

Ms. Connell. Mr. Bertocchi, how much time does he have?

CLERK: Four minutes.

MR. BERTOCCHI: Thank you, your Honor. Your Honors, nothing in this record suggests that the D&X or the procedure described in this statute may be the safest. No doctor says that in the --

JUDGE POSNER: Is there some reason why there isn't a health exception in the statute?

MR. BERTOCCHI: Your Honor, I don't think a health exception -- I don't think the legislature found it to be necessary because they concluded, after examining the evidence, the constitutional facts of this case, that this ban does not present a health issue. The health exception --

JUDGE WOOD: But how can the legislature know for each individual woman that -- the population for whom this matters, that all doctors looking at all women will always conclude that this isn't a preferable procedure?

We're using the word necessary, but there's also a concept of preferable. You know, and the example given is that yes. I mean, it may be that this is a very good procedure, but you might be able to take care of a particular woman's problem by performing a hysterectomy on her too. That will get rid of the fetus as well as other things.

MR. BERTOCCHI: Your Honor --

JUDGE WOOD: But I don't see how it's -- how the legislature can say under the Supreme Court's jurisprudence that a particular medical procedure is never a preferable procedure for anyone.

MR. BERTOCCHI: Your Honor, the legislature can say that because it examined pronouncements from significant medical groups that said that.

JUDGE WOOD: But there were other pronouncements that the District Court found took a different view.

MR. BERTOCCHI: Your Honor, this is a facial challenge. The Plaintiffs are not

trying to throw the statute out as to any particular way the --

JUDGE WOOD: Well, but remember under Casey it's the population for whom this makes a difference; that is to say the people who might need this procedure that --

MR. BERTOCCHI: Your Honor, assuming the --

JUDGE WOOD: -- and are the relevant group.

MR. BERTOCCHI: Assuming the Court rejects our Salerno argument, that would be true.

JUDGE WOOD: Right.

MR. BERTOCCHI: But the fraction is -- in this case, according to the view of the legislature looking at the big picture, the facial picture if you will, is that the fraction is not of appreciable size.

JUDGE POSNER: Well, why do you think doctors ever use this procedure then?

MR. BERTOCCHI: Your Honor, I don't think that there's been any demonstration that doctors in Illinois do.

JUDGE POSNER: No, no. But there are --

MR. BERTOCCHI: Why would a doctor?

JUDGE POSNER: No, no. Many of these procee -- in our Wisconsin case, there is a reference several thousand of them. If it's never any better for the mother, why would the doctors perform this? Is it sadistic or...

MR. BERTOCCHI: I think that their -- I can't speak to the Plaintiffs, because they're pretty distinguished, and frankly I don't think they would, and I certainly don't think they've said they would. I can't imagine --

JUDGE POSNER: I understand --

MR. BERTOCCHI: I recall in one of --

JUDGE POSNER: There are reputable doctors who perform the D&X procedure, and you know, the ACOG approves it as legitimate. So why do you think these -- why do you think doctors ever would do a procedure that wasn't good for the mother?

MR. BERTOCCHI: Your Honor, I'd respond in two ways. One is I think that they might do it -- one reason that comes to mind might be for convenience because it might be faster, and the other is I don't think that the ACOG or the AMA have approved this. I think --

JUDGE ROVNER: The ACOG does --

MR. BERTOCCHI: -- as a matter of fact that they said the opposite.

JUDGE EVANS: Mr. Bertocchi, you said earlier in response to one of the Chief Judge's questions that if a doctor embarked on a D&E --

MR. BERTOCCHI: Yes.

JUDGE EVANS: -- procedure but changed her mind mid course and decided that a D&X would be preferable here, there'd be no prosecution under the Illinois law because there was no intent going in.

MR. BERTOCCHI: No knowledge --

JUDGE EVANS: That's what you said I believe --

MR. BERTOCCHI: Yes --

JUDGE EVANS: -- is that correct?
MR. BERTOCCHI: Yes, your Honor.
JUDGE EVANS: Will a doctor in the heat of a surgical procedure make those kind of fine distinctions that you're drawing here or will the doctor refrain from the D&X because of fear that a jury or a judge or a prosecutor somewhere will not draw those distinctions?
MR. BERTOCCHI: Your Honor, I believe that that is what is beneficial and that is what makes the statute constitutional in terms of the knowledge requirement. Ms. Connell says that this statute does not prescribe a fixed state of mind, and she's wrong. Because the word knowingly applies to the whole procedure and not separately to its parts, it isn't a question so much of what the doctor wants to do in the heat of surgery. It's a question of what the doctor does in the cool of the hallway walking in or in his in his office, but not in the middle of a procedure.
JUDGE WOOD: But where in the

statute does it say how many minutes before you do it you form the intent?

MR. BERTOCCHI: It doesn't say --

JUDGE WOOD: Ten minutes enough?

MR. BERTOCCHI: It doesn't say that in any criminal --

JUDGE WOOD: Two minutes?

MR. BERTOCCHI: -- statute, Judge.

JUDGE WOOD: 30 seconds? I mean, I want to know when you think this intent has to -- why you think its in the hallway instead of --

MR. BERTOCCHI: I think -- well, I'm not sure it's not --

JUDGE WOOD: -- 30 seconds before he does it.

MR. BERTOCCHI: I'm not sure -- the hallway may be an exaggeration. It's before the procedure that's described in the statute begins.

JUDGE WOOD: But what if it's 30 seconds before? The doctor gets the woman all ready and says oh, you know, it looks like this is going to work --

MR. BERTOCCHI: You mean it's going to be --

JUDGE WOOD: -- best.

MR. BERTOCCHI: -- a D&E you mean?

JUDGE WOOD: Yeah.

MR. BERTOCCHI: If it's 30 seconds before he starts, then he doesn't have the state of mind when he carries out all three steps.

JUDGE WOOD: Before he starts?

MR. BERTOCCHI: Yes. He has to have that knowledge at each -- the complete knowledge at each of the steps. That's the way the statute's drafted, your Honor. I see my time has expired.

JUDGE POSNER: Do you want another minute? You were peppered with questions.

MR. BERTOCCHI: Your Honor, I would like to take another minute if I might to refer to Ms. Connell's addressing what the state legislature wants. And I can tell you what the state legislature wants and what the Supreme Court would have to do under Illinois law.

The state legislature tried very hard in this instance to draft a statute that would be enforceable, that would not be struck down. They spent --

JUDGE POSNER: Why didn't it just adopt the ACOG definition?

MR. BERTOCCHI: I don't think they have to do that in order to make this constitutional, your Honor.

JUDGE POSNER: No, no. But if they want to make it narrow, why isn't that the simplest way to do it?

MR. BERTOCCHI: I don't think they wanted to make it that narrow, but I think they didn't feel they had to make it that narrow to satisfy the Constitution. They want this statute to be upheld.

Ms. Connell said that the legislator wanted -- legislature wanted a statute that was as broad as possible, and I think in a sense she's right. But you have to include constitutionality within --

JUDGE POSNER: Wait. I've lost you.

MR. BERTOCCHI: -- the realm of the possible.

JUDGE POSNER: As broad as possible? Narrow as possible? I'm lost.

MR. BERTOCCHI: Well, the legislature wanted a statute that would pass constitutional muster. They didn't want evasion, but they didn't want to cover procedures that are protected. This -- the animating concern of this -- that got this statute passed was a group of pro-choice legislators who felt that while they maintained their pro-choice views, they felt that this statute that covered a procedure wherein the fetus had passed into their zone of interest.

But they were conscious, all of the legislators, if you look in the house and senate debates, remained conscious throughout of the woman's rights as guaranteed by the Constitution. And I think they tried very hard to use the right kind of evidence and make that decision, and I believe they succeeded.

JUDGE ROVNER: Even without an exception for the woman's health or even her life, it's at risk for --

MR. BERTOCCHI: There is a life exception actually, your Honor.

JUDGE ROVNER: -- a mental health reason.

MR. BERTOCCHI: Well, I'm not -- I don't know that that's a distinction, but your Honor, I would -- my response to that is that I think what the legislature concluded, based on proper evidence that it was proper for them to rely on is that there was no health issue here.

If they had thought there was, I don't know the statute would have passed. And I think that the evidence they relied on, which is also in this record, was reliable and permissible for them to do so. Thank you, your Honors.

JUDGE POSNER: Thank you, Mr. Bertocchi. Thank you to both counsel.

(End of Tape)

PAMELA A. STAFFORD, being first duly sworn on oath says that she is a court reporter doing business in the City of Chicago and that she transcribed an audiotape, and that the foregoing is a true and correct transcript of said audiotape to the best of her ability.

/s/ Pamela A. Stafford.
Certified Shorthand Reporter

SUBSCRIBED AND SWORN TO
before me this 27 day
of December, 1999.

Donna M. Guadgnola.
Notary Public

ACOG *STATEMENT OF POLICY*
As issued by the ACOG Executive Board

STATEMENT ON INTACT DILATION AND EXTRACTION

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial-birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as "Intact Dilatation and Extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilation of the cervix, usually over a sequence of days;

2. instrumental conversion of the fetus to a footling breech;

3. breech extraction of the body excepting the head; **and**

4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four

elements are present in sequence, the procedure is not an intact D & X.

Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D &X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the **only** option to save the life or preserve the health of the woman. An intact D & X however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. **The intervention of legislative bodies**

into medical decision making is inappropriate, ill advised, and dangerous.

Approved by the Executive Board
January 12, 1997

American Medical Association
Physicians dedicated to the health of America

Statement

May 14, 1997

Statement is attributable to: Nancy Dickey, MD
Chair
American Medical Association

LATE TERM ABORTION

"The American Medical Association Board of Trustees has forwarded to its House of Delegates for its consideration at AMA's Annual Meeting in June a report regarding late term abortions as requested by the House at its last meeting (December 1996). The report does not become AMA policy until approved by the House of Delegates. The report, which is based on the advice of an expert panel convened by the AMA and consisting of representatives from American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics and AMA Councils on Ethics, Scientific Affairs and Legislation, reaffirms existing policy that abortion is a medical procedure subject to state laws and the standards of good medical practice.

"The report finds there is no 'identified situation' where intact dilation and extraction or intact D&X (sometimes referred to as "partial birth abortion") is the 'only appropriate procedure' to induce abortion and it recommends against the

use of the procedure except in unforeseen circumstances where it may be absolutely necessary.

"In addition, the report recommends that physicians not use abortion procedures for terminating pregnancies in the third trimester, other than in extraordinary circumstances or where severe fetal anomalies inconsistent with life exist, because sacrificing the fetus and/or destruction of the fetus is rarely necessary even when ending the pregnancy to preserve the life or health of the mother. Finally, the report calls on the medical profession, community organizations and the government to initiate more aggressive education efforts in order to reduce the demand for abortions generally.

"The report does not directly address any pending legislation regarding 'partial birth abortion.' The AMA does not support any legislative proposals at this time."

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